

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

37591

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *Christian Hospital*)

File No.....
Registered No. *10674*
St..... Ward.....

2. FULL NAME

(a) Residence. No. *8721 Halls Ferry Rd.* Ward. *8*

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Augusta Charles*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 13 1862*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 8 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Supt.*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer *Lutheran Altemheim*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

PARENTS

10. NAME OF FATHER *August Charles*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER *Augusta Bergman*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

14.

INFORMANT *Augusta Charles*
(Address) *10 8721 Halls Ferry Rd*

15.

FILED *11 1936* 19 *Max C. Stuber* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11/8 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 10 1930* to *Nov. 8 1930* that I last saw him alive on *Nov. 7 1930*, and that death occurred, on the date stated above, at *5 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis

(duration) *1* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) *1 29 W* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DISEASE?

(Signed) *J. A. Van Hoefen*, M. D.

11/8/30 (Address) *8313 Halls Ferry Rd*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

New Bethlehem Cem Nov. 11 1930

20. UNDERTAKER

ADDRESS

Chas. H. Reidenwieser St Louis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

