

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

Do not use this space.

38620

PLACE OF DEATH

County Puchanan
Township _____
City St. Joseph, (No. _____)

Registration District No. 85
Primary Registration District No. 1001
Missouri Methodist Hospital

File No. _____
Registered No. 1359
St. _____ Ward _____

2. FULL NAME Rudolph Phildius

(a) Residence. No. 2314 South 15th St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single,

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22, 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53 4 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer) C.B. & Q. Ry. Co.
(c) Name of employer Secretary

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Germany,

10. NAME OF FATHER Adolph Phildius

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

12. MAIDEN NAME OF MOTHER Clara Opperman

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

14. INFORMANT Heroman Phildius
(Address) 2314 South 15th Street,

15. FILED 4 1930 REGISTRAR John G. [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 22 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Dec 22, 1930 that I last saw him alive on Dec 22, 1930, and that death occurred, on the date stated above, at 10:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Syphilis Tertiary
74
(duration) 15 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Syphilis of central nervous system (duration) 4 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 DIAGNOSIS Hasserman
(Signed) H. W. Kearley, M. D.

Dec 23, 1930 (Address) St Joseph Mo.

*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 Ashland Cemetery DATE OF BURIAL Dec. 26 1930

20. UNDERTAKER Heaton-Bryce & Bowman ADDRESS 319 S. 10 St.
Diverse Home

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.

JAN 19 1930

DEC 4 1930

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