

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

Do not use this space.

12291

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis (No. City Hosp)

21870

File No.
Registered No. 13554
St. Ward

2. FULL NAME

(a) Residence. No. 8521 Orleans St. / Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 60 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 24 - 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 1 9 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Laborer 231
(b) General nature of industry, business, or establishment in which employed (or employer). unemployed
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 10

10. NAME OF FATHER Jacob Behr

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

12. MAIDEN NAME OF MOTHER unavailable

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) " 31

14. INFORMANT (Address) Hospital Information Grace Kopp City Hospital

15. FILED 23 1931 May W. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 20th 1931

17. I HEREBY CERTIFY, That I attended deceased from Mar. 16th 1931 to Mar. 20th 1931 that I last saw him alive on Mar 20th 1931, and that death occurred, on the date stated above, at 3.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

lobar pneumonia
108 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 108 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF ①

WAS THERE AN AUTOPSY? refused

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Rescherman M. D.
3/20, 1931 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or if 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 St. Peter & Paul Cem DATE OF BURIAL 3/24 31

20. UNDERTAKER E. Hoffmeister 214 1/2 ADDRESS 814 8thway

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Behr

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