

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

Do not use this space.

16225

**1. PLACE OF DEATH**

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

Registration District No. **791**  
**1003**  
Primary Registration District No. *2008 Biddle*

File No.....  
Registered No. **4707**  
St..... Ward.....

**2. FULL NAME**

(a) Residence. No. *2068 Biddle* St., *21* Ward.

(If nonresident, give city or town and State)

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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*all 65* ✓ ✓

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). *Unknown*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT *Geo. W. Kerner*  
(Address) *Evermore Office*

15. *20 1931*  
FILED *20 1931* REGISTRAR *Max C. Tardiff*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 16 1931*

17. *No Physician Attendance*  
HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him ..... alive on ..... 19..... and that death occurred, on the date stated above, at..... *850*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Asphyxiation due to fumes Gas Poisoning*  
*1913* (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Whether Accidental or Intention Not Ascertained*

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  
(Signed) *J. W. Kerner M.D.*

*430* 19 *31* (Address) *Dep. Coroner*

\*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  
*Mt. Hope Cemetery E. St. L.* *4/21 1931*

20. UNDERTAKER *Not ascertainable* ADDRESS *2621 Ziegenhain Bldg. Cherokee*

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.

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