

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

Do not use this space.

1. PLACE OF DEATH

County

Registration District No. **791**

Township

Primary Registration District No. **1507**

City **St. Louis** (No. **1193**)

City **City Hosp.**

File No. **19315**

Registered No. **5250**

St.

Ward)

2. FULL NAME

(a) Residence. No. **1820 Carr (rear) 21** St. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **15** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (<i>write the word</i>) <i>married</i>
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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.
<i>abh.</i>	<i>51</i>			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Chauffeur*

(b) General nature of industry, business, or establishment in which employed (or employer) *11.5*

(c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *No special Informant*
Pharce Kopp
(Address) *City Hospital*

15. FILED *1931* *City Hospital*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2.
16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 1st 1931*

17.
I HEREBY CERTIFY, That I attended deceased from *April 20th, 1931*, to *May 1st, 1931*, that I last saw him alive on *May 1st, 1931*, and that death occurred, on the date stated above, at *13.05 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pericardial Abscess
1931 (Cause unknown)
100A

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *Thrombophlebitis of Right Leg*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF *1931*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *Carl J. Hoh*, M. D.
571, 1931 (Address) City Hosp.

*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 *Calvary Cemetery* **DATE OF BURIAL** *May 4, 1931*

20. UNDERTAKER *Paul C. Calaterra* **ADDRESS** *1921 Cooper St.*

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.

Trachinotus