

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

Do not use this space.

19605

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No.

Registered No. **5567**

St. Ward)

2. FULL NAME

(a) Residence. No. *1726 So. Broadway* (near *23*)
(Usual place of abode) Ward.

Length of residence in city or town where death occurred *8* 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) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *not known*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 19, 1857*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 1 21

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) *Carpenter*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *France - 4*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. Hospital Information INFORMANT *Gracet Sepp* (Address) *City Hospital*

15. FILED *14 19* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 10, 1931*

17. I HEREBY CERTIFY, That I attended deceased from *May 7, 1931* to *May 10, 1931*, that I last saw him alive on *May 10, 1931*, and that death occurred, on the date stated above, at *7:20 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic cardiovascular renal disease

CONTRIBUTORY (SECONDARY) *Senile Dementia* (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH, NO DATE OF WAS THERE AN AUTOPSY? *refused*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical + laboratory* (Signed) *W. Scherman*, M. D.

5711 19 31 (Address) *City Hospital*

*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
Bethania Cemetery *May 15 1931*

20. UNDERTAKER ADDRESS
H. Rindskopf *5216 Delmar*

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.

