

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

Do not use this space.

26671

1. PLACE OF DEATH

County.....
Township.....
City.....

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

File No.....
Registered No. **7844**
St..... Ward.....

2. FULL NAME

(a) Residence, No. **1010 N. Russell** Ward **11**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **40** 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 Col	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-28-1890		
7. AGE	YEARS 41	MONTHS 4
	DAYS 12	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Laborer	
	10. Date deceased last worked at this occupation (month and year) Unknown	11. Total time (years) spent in this occupation Unknown
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Massena		
FATHER	13. NAME Wm Lueky	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Massena	
MOTHER	15. MAIDEN NAME Luey Kitchlights	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no	
17. INFORMANT (ADDRESS) A. Burkhardt, death # City Drop #2		
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter's DATE 7/16 19 31		
19. UNDERTAKER (ADDRESS) Manuel Undertaking Co 4059 Filbert St		
20. FILED LL 15 1931 Registrar C. M. Smith		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-10-1931**

22. I HEREBY CERTIFY, That I attended deceased from **7-7-1931** to **7-10-1931**
I last saw him alive on **7-10-1931** Death is said to have occurred on the date stated above, at **510** K m.
The principal cause of death and related causes of importance were as follows:
89-A
Cerebral Hemorrhage 3 day
Other contributory causes of importance:
82W
Name of operation **Autopsy** Date of.....
What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **C. M. Smith** (Signed)..... M. D.
(Address) **City Drop #2**

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.

