

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

Do not use this space.

29804

1. PLACE OF DEATH

County.....
Township.....
City..... (No.....)

Registration District No.....
Primary Registration District No.....

File No.....
Registered No. **8846**
St. _____ Ward)

2. FULL NAME

Allen W. Woskin
(a) Residence. No. *5565 Holman* St. *7* Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *1* yrs. - *mes.* - *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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *9-10-1904*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26 11 6

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
St. Louis

10. NAME OF FATHER *Max W. Woskin*

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

12. MAIDEN NAME OF MOTHER *Stolowskoff*

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

14. INFORMANT *Joe J. Adkins*
(Address) *ISOLATION HOSPITAL*

15. FILED *18 1931* *W. C. Starck*
REGISTRAR

*781
009*

ISOLATION HOSPITAL

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from *Aug 10* 19*31* to *Aug 16* 19*31* that I last saw him alive on *Aug 16* 19*31* and that death occurred, on the date stated above, at *10:20 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
meningitis, Epidemic
18
92B

CONTRIBUTORY (SECONDARY) *Tuberculosis Cerebral* (duration) yrs. mos. *8* ds.
Veins (duration) yrs. mos. *1* ds.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

19. WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Abrent Cardiac Action*

(Signed) *John Eschenbrenner*

8/17, 1931 (Address) **ISOLATION HOSPITAL**
*State the DISEASE CAUSING DEATH, or in death from VIOLENCE, CAUSES, STAGE (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Rehesh St. Emeth* DATE OF BURIAL *8/18 1931*

20. UNDERTAKER *H. B. Berger* ADDRESS *4715 McPherson*

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.

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

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