

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

Do not use this space.

32660

1. PLACE OF DEATH

County.....

Registration District No. 701

Township.....

Primary Registration District No. 703

City St. Louis

(No. City Hospital # 1)

File No.

Registered No. 9495

St.

Ward)

2. FULL NAME

(a) Residence. No. 3606 N. Broadway

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mo.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

(If nonresident give city or town and State)

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) Oct 14th 1905

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>25</u>		<u>10</u>	<u>25</u>	

8. OCCUPATION OF DECEASED

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

Paper Hanger

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Austria Hungary

10. NAME OF FATHER

Joseph Rosenberger

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Austria Hungary

12. MAIDEN NAME OF MOTHER

Anna Walter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Austria Hungary

14.

INFORMANT (Address)

Joseph Rosenberger
12301 Palm St

15.

SEPT - 9 1931
FILED

Max C. St. Vincent
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 8, 1931

17. No Physician in attendance. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19.....

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries Fractured Skull Result of When Jumping from Window at City Hospital

CONTRIBUTORY (SECONDARY)

1674 St. Louis Mo. (duration)..... yrs. mos. da.

While suffering from temporary mental aberration (duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

Suicide

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kerney M.D.

9/9, 1931 (Address) Deputy 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

Calvary Cem

DATE OF BURIAL

Sept 10th 1931

20. UNDERTAKER

Edward Koch

ADDRESS

3516 1/2 14th

COPIES OF THIS RECORD WILL BE MADE 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.

