

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.

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

Do not use this space.

10507

1. PLACE OF DEATH

County.....  
Township.....  
City *St. Louis*

Registration District No.....  
Primary Registration District No.....  
(No. *General Hospital*)

File No.....  
Registered No. *2571*  
St..... Ward)

2. FULL NAME

(a) Residence, No. *5793 Westminster St.*, *5* Ward.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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 (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Jennie Marks</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Sept. 4 - 1868</i>		
7. AGE	YEARS <i>63</i>	MONTHS <i>6</i>
	DAYS <i>13</i>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as splaner, sawyer, bookkeeper, etc. <i>Furniture Salesman</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>172 117A</i>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation <i>17 1/2</i>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>New York N.Y.</i>		
FATHER	13. NAME <i>Abraham Marks</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>	
MOTHER	15. MAIDEN NAME <i>Belie Harris</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>New York N.Y.</i>	
17. INFORMANT (ADDRESS) <i>Jennie B. Marks 5793 Westminster</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Mt. Sinai Cem.</i> DATE <i>March 18, 1932</i>		
19. UNDERTAKER (ADDRESS) <i>A. Handstorf 216 Belmont</i>		
20. FILED: <i>1 27 1932</i> 19 <i>May C. Staker</i> Registrar		

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar. 17*, 19*32*

22. I HEREBY CERTIFY, That I attended deceased from *Mar. 10*, 19*32*, to *Mar. 17*, 19*32*  
I last saw him alive on *Mar. 17*, 19*32*. Death is said to have occurred on the date stated above, at *7:30 a.m.*  
The principal cause of death and related causes of importance were as follows:  
*Acute Dilatation of Stomach  
Phalagytic illness  
of post-operative*

Other contributory causes of importance:  
*Diabetic edema of Stomach*

Name of operation *Exploratory Laparotomy* Date of *3/15/32*  
What test confirmed diagnosis? *Central* Was there an autopsy? *No.*

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 *Carl G. Steinhilber* M. D.  
(Signed) *Carl G. Steinhilber* M. D.  
(Address) *Dept. of Hospital*

