

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

Do not use this space.

27641

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City *St. Louis* (No. *City Hospital*)
8089

File No.....
Registered No. *7459*
St. Ward)

2. FULL NAME

(a) Residence, No. *2135 Allen* St. *23* Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *20* 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) *married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 4-1872*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 4 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Laborer*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *237*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria 3*

13. NAME *Joseph Schaff*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*

15. MAIDEN NAME *Frances Aller*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*

17. INFORMANT (ADDRESS) *Hospital information Grace Hosp*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Louis, Missouri Aug 16, 1932*

19. UNDERTAKER (ADDRESS) *Crede's*

20. FILED *AUG 15 1932*

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 12, 1932*

22. I HEREBY CERTIFY That I attended deceased from *Aug. 12th, 1932* to *Aug. 12th, 1932*

I last saw him/her alive on *Aug. 12, 1932*. Death is said to have occurred on the date stated above, at *11:55 P.M.*

The principal cause of death and related causes of importance were as follows:

Generalized Peritonitis
46
1932
46
Other contributory causes of importance:
Perforation of Cecum of ileum

Name of operation *Resection of sigmoid & distal colon* Date of *8/12/32*
What test confirmed diagnosis? *Operation* 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 *No*

(Signed) *Marshall A. Decker* M. D.
(Address) *City Hospital*

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.

21 11.