

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

Do not use this space.

30339

1. PLACE OF DEATH

96 County St. Louis Registration District No. 1170 File No. _____
 Township _____ Primary Registration District No. 6248H Registered No. 179
 City Richman Heights (No. St. Marys Hospital) St. _____ Ward _____

2. FULL NAME

Robert Cordes
 (a) Residence. No. 7506 North Broadway St. _____ 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. _____ da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

SAL. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 6, 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 4 17

8. OCCUPATION OF DECEASED None
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER William A. Cordes

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Dorothy Henderson

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

14. INFORMANT William A. Cordes (Address) 7506 North Broadway

15. FILED 9/24 19 32 C. L. Jordan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 23 1932

17. I HEREBY CERTIFY, That I attended deceased from 9-10-32 to 9-23-32 that I last saw h. s. m. alive on 9-23, 1932, and that death occurred, on the date stated above, at 7:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1. Malaria
2. Congenital respiratory stidor
101D (duration) yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) 158 / 158 (duration) yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? DATE OF 1

19. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS (Signed) Patricia G. Davis, M. D. 19 (Address) St. Marys Hosp.

*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 Friedens DATE OF BURIAL Sept 26 1932

20. UNDERTAKER Mat. Hermann & Son ADDRESS 4161 East Fairview

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.

901 29 1932

