

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

Do not use this space.

41987

1. PLACE OF DEATH

County..... Registration District No. *7011*
 Township..... Primary Registration District No. *10123*
 City, *St. Louis Mo.* (No. *2927 Minnesota Ave.* File No. *11108*
 Registered No. *11108* Ward)

2. FULL NAME

(a) Residence. No. *16* St., *16* 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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 17 1873*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 1 25

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

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

10. NAME OF FATHER *Unknown Maude*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *John J. Geran*
 (Address) *2927 Minnesota Ave*

15. FILED *DEC 14 1932* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 12 1932*

17. I HEREBY CERTIFY, That I attended deceased from *June 2 1930* to *Dec 12 1932* that I last saw h. *Ex.* alive on *Dec 12 1932*, and that death occurred, on the date stated above, at *11:04 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cardiac Failure
Chronic Myocarditis
Toxic Thyroid Adenoma
Chronic Toxic Induration

CONTRIBUTORY (SECONDARY) *W.B.*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, *No*

DID AN OPERATION PRECEDE DEATH, DATE OF *No*

WHAT TEST CONFIRMED DIAGNOSIS *Tab. test & Ray*

(Signed) *P. S. Paugh*, M. D.
 1932 (Address) *444 N. Euclid*

*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 *St. Peter & Paul Cemetery* DATE OF BURIAL *Dec 15 1932*

20. UNDERTAKER *John J. Robert* ADDRESS *1415 S Grand*

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.

UNREPRODUCIBLE COPY RESERVED FOR BINDING

V. E. NO. 2.

