

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

Do not use this space.

11113

1. PLACE OF DEATH

County.....

Registration District No. **701**

File No. **1008**

Township.....

Primary Registration District No. **1008**

Registered No. **2150**

City **St. Louis Mo.** (No. **Missouri Baptist Hospital** Ward)

2. FULL NAME

(a) Residence. No. **4152 Cleveland** St., **17** 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

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

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

March 25-1926

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
6	11	6	

8. OCCUPATION OF DECEASED

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

School boy

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

Char Michael School

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Mo.

10. NAME OF FATHER

George C. Hinkelmann

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

12. MAIDEN NAME OF MOTHER

Nellie Fisher

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.

INFORMANT

(Address)

*Nellie Hinkelmann
4152 Cleveland Ave*

15.

FILED

*May C. Farley
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

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

Mar 1 1933

17.

I HEREBY CERTIFY, That I attended deceased from *Feb 18*, 19*33*, to *Mar 1*, 19*33*.
that I last saw him alive on *Mar 1*, 19*33*, and that death occurred, on the date stated above, at *4:17 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mastoiditis, meningitis (type undetermined not epidemic)

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH. *yes* DATE OF *Mar 1-33*

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *operation + lumbar*

(Signed) *J. W. White*, M. D.

Mar 2, 1933 (Address) *4500 Olive*

*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

DATE OF BURIAL

Calvary Cemetery Mar 4 1933

20. UNDERTAKER

ADDRESS

Wm. J. Roberts 1945 S Grand Blvd

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.

