

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.

11846

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1002**
City **St. Louis** (No. **3231**, Ohio) St. _____ Ward _____

File No. _____
Registered No. **2952**

2. FULL NAME

(a) Residence, No. **3231**, **Ohio Ave** St., **24** Ward. (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 **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 **Caroline Hilttenbrand**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb 8-1865**

7. AGE YEARS **68** MONTHS **1** DAYS **19** If LESS than 1 day, _____ hrs. _____ min.

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

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

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) **France**

13. NAME **Unknown**

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

15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Caroline Hilttenbrand**

(ADDRESS) **3231- Ohio Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **May 30**, 19**33**

19. UNDERTAKER **Wacker, Helderle**

(ADDRESS) **2331 St. Charles**

20. FILED **MAY 28 1933** **May C. Stanley** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 27**, 19**33**

22. I HEREBY CERTIFY, That I attended deceased from **February 15th 1933** to **March 21st 1933**
I last saw him alive on **March 21st 1933**. Death is said to have occurred on the date stated above, at **2 P.M.**

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

Carcinoma Larynx
47A
690 47A

Other contributory causes of importance:
General Toxic Condition

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19**33**

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 _____

(Signed) **D. John Bushman**, M. D.

(Address) **330 California av**

