

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

EB 27 1934

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *City Hospital*)

Registration District No. *791*
Primary Registration District No. *1003*

File No. *2804*
Registered No. *443*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *2024 Angelen* St. _____ Ward *26*
(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. COLOR OR RACE <i>W.</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>?</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>May 19-1864</i>		
7. AGE YEARS <i>69</i>	MONTHS <i>7</i>	DAYS <i>62</i>
		If LESS than 1 day, hrs. or min.

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

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) *Bloomfield Tenn*

13. NAME *John Seism*

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

15. MAIDEN NAME *Guensia M. Peters*

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

17. INFORMANT *Dr. J. M. Kent* (ADDRESS) *City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Bloomfield, Mo* DATE *Jan 13 1934*

19. UNDERTAKER *W. H. Hermann & Son* (ADDRESS) *3161 East 7th St. St. Louis*

20. FILED *1934* *J. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 11 1934*

22. I HEREBY CERTIFY That I attended deceased from *12/28 1933* to *1/11 1934*

I last saw him alive on *1/10 1934* Death is said to have occurred on the date stated above, at *2:30* m.

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

Cholelithiasis
Cholelithiasis
Bronchopneumonia
Cholecystomy 10/34

Other contributory causes of importance _____

Name of operation _____ Date _____

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____
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) *J. J. Sauer* M. D.
(Address) *City Hospital*

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.

RECEIVED
FEBRUARY
1944