

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.

FEB 27 1934

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

Do not use this space.

2928

1. PLACE OF DEATH

County ..... Registration District No. **791**  
Township ..... Primary Registration District No. **1003** File No. ....  
City **St. Louis** (No. **4430**) **Burcher St** Registered No. **572**  
St. .... Ward)

2. FULL NAME

(a) Residence, No. **4620 Burcher St** St. **7** 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Josephine Lang</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>April 15-1854</i>		
7. AGE YEARS <i>79</i>	MONTHS <i>8</i>	DAYS <i>30</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Carpenter</i>		If LESS than 1 day, ..... hrs. or ..... min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>retired</i>		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

13. NAME *Ferdinand Lang*

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

15. MAIDEN NAME *Mary Kisser*

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

17. INFORMANT *Josephine Lang*  
(ADDRESS) *4620 Burcher St*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *Cemetery* DATE *Jan 17 1934*

19. UNDERTAKER *Dr. Mansfield Ind. Co.*  
(ADDRESS) *4742 St. Charles Ave*

20. FILED *J. Brebeck*  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1/14/34*  
22. I HEREBY CERTIFY, That I attended deceased from *10/16/29* to *1/14/34*  
I last saw h. alive on *1/14/34* Death is said to have occurred on the date stated above, at *3:20 p.m.*  
The principal cause of death and related causes of importance were as follows:

*Acute Hypostatic*  
*100% Broncho Pneumonia*  
*Secondary*  
*Senile Arterio Sclerosis*  
Date of onset *1/13/34*

Name of operation *none* Date of *none*  
What test confirmed *clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? *no* Date of injury *no*, 19...  
Where did injury occur? *no* (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. *none*  
Manner of injury *none*  
Nature of injury *none*

24. Was disease or injury in any way related to occupation of deceased? *no*  
If so, specify *Chas P. Protant*, M. D.  
(Signed) *Chas P. Protant*  
(Address) *3903 Lee Ave*

