

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

Do not use this space.

7301

APR 25 1934

PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. **2320**

Registered No. **2320**

2. FULL NAME **Michael Abram**

(a) Residence, No. **3209 Walnut St. 25** 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 **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **abt. 54**

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

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

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) **Texas**

13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **11**

15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **11**

17. INFORMANT **Harp Lutz Patient** (ADDRESS) **1444 Dup**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Houston Tex** DATE **3-8** 193**4**

19. UNDERTAKER **Teat Bros** (ADDRESS) **2024 Lafayette Ave**

20. FILED **10 10 34** 19**34** **J. B. Brebeck** Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/27** 19**34**

22. I HEREBY CERTIFY, That I attended deceased from **2/26** 19**34** to **2/27** 19**34**

I last saw him alive on **2/27** 19**34** Death is said

to have occurred on the date stated above, at **15th floor**

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

Bronchial Pneumonia
Chronic Arteriosclerosis
Coronary Atherosclerosis? } **2-26-34**

Other contributory causes of importance:

Name of operation **93 C** Date of **10/11**
What test confirmed diagnosis? **celiac** Was there an autopsy? **Yes**

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

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) **Arthur H. Hayes**, M. D.

(Address) **City Harp**

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.

