

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.

1. PLACE OF DEATH St. Louis Mo.

791
1003

21803

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. Barnes) Lozj..... St. Ward.....

File No.....
Registered No. 5520
St. Ward.....

2. FULL NAME Jack Jacob Thomas Stetzingee
(a) Residence, No. 209 W 14TH St., NR Ward. Flora Ill.
(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 23-1918</u>				
7. AGE	YEARS <u>15</u>	MONTHS <u>11</u>	DAYS <u>8</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Student</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>1918</u>			
	10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation..... <u>3</u>			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield Ill.</u>				
FATHER	13. NAME <u>Thomas Stetzingee</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Portsmouth Ohio</u>			
MOTHER	15. MAIDEN NAME <u>Dena Ray</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Alton Ill.</u>			
17. INFORMANT <u>Dena Stetzingee</u> (ADDRESS) <u>Flora Ill.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Flora Ill.</u> DATE <u>6-3</u> , 19 <u>34</u>				
19. UNDERTAKER <u>Albert H. Happe</u> (ADDRESS) <u>4224 Euclid Ave.</u>				
20. FILED <u>-2</u> 19 <u>34</u> <u>19</u> <u>Joe J. Brebeck</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

3

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-1, 1934

22. I HEREBY CERTIFY, That I attended deceased from 2-29, 1934, to 6-1, 1934.
I last saw him alive on 6-1, 1934. Death is said to have occurred on the date stated above, at 9:10 A.M.
The principal cause of death and related causes of importance were as follows:
107 Bronchopneumonia
Staphylococci infection of bone (cause unknown)
107A
Other contributory causes of importance:
154 Osteomyelitis for about 8 months (Right femur) - non-tuberculous

Name of operation..... Date of.....
What test confirmed diagnosis? Autopsy 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....., 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) Robert S. Smith, M. D.
(Address) Barnes Hospital

