

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

Do not use this space.

30889

1. PLACE OF DEATH

County.....**SEP 13 1934**..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)

File No.
Registered No. **8152**
St. Ward)

2. FULL NAME

(a) Residence, No. **2246** **Dodier 20** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **70** yrs. **11** mos. **26** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Aug 7 1934**

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

22. I HEREBY CERTIFY, That I attended deceased from **7/23** 19**34** to **8/7** 19**34**
I last saw him alive on **8/7** 19**34**. Death is said to have occurred on the date stated above, at **11:30** a.m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 11 - 1863**

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 **11** **26**

Urthral Stricture for 50 years due to numerous infections for treatment of gonorrhoea

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

350
Other contributory causes of importance:
Prostatic Hypertrophy, Gonorrhoea

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? **NO**

13. NAME **Not known**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

15. MAIDEN NAME **Not known**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

17. INFORMANT (ADDRESS) **Wasp Day Hospital**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cemetery** DATE **Aug 10** 19**34**

19. UNDERTAKER (ADDRESS) **Goodhart & Goodhart 2208 Sedgewick Ave**

20. FILED **2208 Sedgewick Ave** 19**34** **W. C. Brebeck** Registrar

Urthral Stricture
Prostatic Hypertrophy
Gonorrhoea

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) **W. C. Brebeck**, M. D.
(Address) **City Hospital**

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.

