

DEC 2 2 1934

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

Do not use this space.

38103

1. PLACE OF DEATH

County *St. Louis*
Township *St. Louis*
City *Koch, Mo.* (No.)

Registration District No. *1173*
Primary Registration District No. *674803*

File No.
Registered No. *392*
St. Ward

2. FULL NAME

(a) Residence, No.

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

C

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Divorced

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

Unknown

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

--- 1898

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*36**-**-*

OCCUPATION

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

*Laborer
Construction Crew*

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)

Louisiana

13. NAME

Unknown

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

Unknown

15. MAIDEN NAME

Unknown

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

Unknown

17. INFORMANT (ADDRESS)

Robert Koch Hosp. Records

18. BURIAL, CREMATION, OR REMOVAL PLACE

*Washington Anatomical Board*DATE *10-20-1934*

19. UNDERTAKER (ADDRESS)

*Walter Richter
3500 Post Gen St*

20. FILED

*11-9**1934**1173 St. Louis, Mo.*

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-13*, 19*34*22. I HEREBY CERTIFY, That I attended deceased from *9-8*, 19*34*, to *10-13*, 19*34*I last saw him alive on *10-13-34*, 19*34*. Death is saidto have occurred on the date stated above, at *12:00 p.m.*

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

Date of onset

Pulmonary Tuberculosis
34
3-27 *3-27*
Other contributory causes of importance:
Syphilis, generalized

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? *no*

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) *Melvin Jess*(Address) *Koch Hosp, Koch*

M. D.

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.

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

