

APR 9 1935

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

Do not use this space.

791
1003

10630

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No.....)

City.....

St.....

St.....

Ward.....

2. FULL NAME

(a) Residence, No.....

(Usual place of abode)

4207 N. Edwards St. Ward. 11

(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)

Widowed

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

Unknown

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

Unknown

7. AGE

YEARS
85

MONTHS

DAYS

If LESS than 1 day,hrs. ormin.

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

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

St. Louis Mo

13. NAME

Unknown

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

Unknown
Unknown

15. MAIDEN NAME

Unknown

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

Unknown

17. INFORMANT (ADDRESS)

Hospital B, East City, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Calvary

DATE

March 9, 1935

19. UNDERTAKER (ADDRESS)

Alice Ludwig & Sons
617 S. Edwards St.
St. Louis, Mo

20. FILED

MAR - 8 1935

J. A. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

3/6

1935

22. I HEREBY CERTIFY, That I attended deceased from

1/27, 1935 to 3/6, 1935

I last saw him alive on 3/6, 1935. Death is said

to have occurred on the date stated above, at 8:30 p.m.

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

Interochranteric fracture of rt femur - fell at home.

186

Other contributory causes of importance:

Sensibility

Pneumonia

Chronic Myocarditis

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

What test confirmed diagnosis?..... Was there an autopsy?.....

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) W. H. Harris, M. D.

(Address) City, Mo

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.

