

MAY 13 1935

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

Do not use this space.

14612

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**City *St. Louis* (No. *City*)File No. **3446**Registered No. **3446**

St. Ward)

2. FULL NAME

(a) Residence, No. *1314* *Wagon* St., *25* Ward. *21*
(Usual place of abode)Length of residence in city or town where death occurred *78* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Single*)5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Single*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 11 - 1856*7. AGE YEARS *78* MONTHS *5* DAYS *4* If LESS than 1 day, hrs. or min.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 *Christian Diel*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*15. MAIDEN NAME *Josephine Licht*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*17. INFORMANT (ADDRESS) *Thos Jay McKeef*18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary* DATE *April 17 1935*19. UNDERTAKER (ADDRESS) *Ang Brookland & Co*20. FILED *APR 16 1935* *J. Brebeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4/15* 19*35*22. I HEREBY CERTIFY, That I attended deceased from *4/6* 19*35* to *7/15* 19*35*I last saw him alive on *7/15* 19*35*. Death is saidto have occurred on the date stated above, at *3:45* m.

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

Branchio Quinomania
Raynaud's gall bladder
Caused by Cholelithiasis
Date of onset *4 days*

Other contributory causes of importance:

Spasm caused by
cholelithiasis *15 days*Name of operation..... *1070* Date of.....What test confirmed diagnosis?..... 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) *H. H. Morris*, M. D.(Address) *City* *St. Louis*

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 CLEARLY, WITH OUPROING INK—THIS IS A PERMANENT RECORD

Blackboard wood