

Do not use this space.

15076

File No.
Registered No. **3963**
St. Ward)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

MAY 13 1935

1. PLACE OF DEATH

County Registration District No. **791**
Township Primary Registration District No. **1003**
City *St. Louis, Mo.* (No.)

2. FULL NAME

(a) Residence, No. *1173 Moorland Dr. N.R.* Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *4-2-35*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, or 5 min.

OCCUPATION

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

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

MOTHER / FATHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis, Mo.*13. NAME *Huckman, Edward*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Lawrence, Mass.*15. MAIDEN NAME *Dorothy Eleanor*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Braintree, Mass.*17. INFORMANT *Edward Huckman* (ADDRESS) *1173 Moorland Dr.*18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Louis, St. Lambert, April 2, 1935*19. UNDERTAKER (ADDRESS) *Dept. of Pathology*20. FILED **APR 30 1935** *J. H. Brudeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 2, 1935*

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19.....

I last saw him alive on *4/2*, 19*35*. Death is saidto have occurred on the date stated above, at *4:30 P.M.*

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

Date of onset

Aseptic 40 hrs

Other contributory causes of importance:

Aseptic Anaphylactic

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, 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) *R. J. Hossen*, M. D.(Address) *6960 Pershing*

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.

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