

SUN 12 1935

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

Do not use this space.

1. PLACE OF DEATH

County .....

Registration District No. **791**

Township .....

Primary Registration District No. **1003**

City *St. Louis, Mo. - St. Louis*

*Children's Hospital - 500 So. Kings Highway* (Ward)

File No. **18299**

Registered No. **4647**

2. FULL NAME *Jack Dechner*

(a) Residence, No. *2418 Reilly* St. *1* Ward.

Length of residence in city or town where death occurred *Life* 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) *Child*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *12-16-34*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
*0 5 7*

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. *child*  
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 *Alex*

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

15. MAIDEN NAME *May Tillman*

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

17. INFORMANT (ADDRESS) *A. Yost 500 So. Kings Highway*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Mt. Olive* DATE *May 29 1935*

19. UNDERTAKER (ADDRESS) *C. Hoffmeister Co. 6724 So. Broadway*

20. FILER *May 25 1935* *J. Brebeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-23 1935*

22. I HEREBY CERTIFY, That I attended deceased from *5-21 1935*, to *5-23 1935*

I last saw h.i.m.: alive on *5-23 1935*. Death is said to have occurred on the date stated above, at *6:15 p.m.*

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

*Meningitis due to pneumococcus* Date of onset *5-18-35*

Other contributory causes of importance:  
*Thrombosis of lateral sinus  
Bronchopneumonia*

Name of operation ..... 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) *Walter B. ...* M. D.  
(Address) *500 So. Kings Highway*

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.

