

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.

AUG 9



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

Do not use this space.

24684

791
1003

File No. _____
Registered No. **6101**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Louis Mo. (No. _____) Sanitarium

2. FULL NAME John Furor

(a) Residence, No. 2709 Wyoming St. 24 Ward _____
(Usual place of abode) (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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs. May Furor</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 28 - 1887</u>		
7. AGE YEARS <u>47</u>	MONTHS <u>4</u>	DAYS <u>6</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Sheet Metal Worker</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Sheet Metal</u>		
10. Date deceased last worked at this occupation (month and year) <u>June 1935</u>		11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 14, 1935

22. I HEREBY CERTIFY That I attended deceased from June 3, 1935 to July 14, 1935.
I last saw him alive on July 14, 1935. Death is said to have occurred on the date stated above, at 8:50 P. m.

The principal cause of death and related causes of importance were as follows:
Terminal Bronchopneumonia Date of onset 7-12-35

Other contributory causes of importance:
Pneumia C. Syphilitic
Prostatic Hypertrophy June 35
June 35

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? no
If so, specify _____
(Signed) R. C. Sinclair M. D.
(Address) City, Sanitarium

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

MOTHER FATHER

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 R. C. Sinclair
(ADDRESS) City, Sanitarium

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Matthews Cemetery DATE July 17, 1935

19. UNDERTAKER J. H. Seltzer
(ADDRESS) 2680 Broadway, Eads

20. JUL 16 1935 19____
J. T. Bredeck
Registrar.

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