

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.

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

Do not use this space.

SEP 16 1935

791
1003

28192

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Louis (No. 2745, Madison St) St. _____ Ward _____

File No. _____
Registered No. 7330
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2745 Madison St., 20 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>May Dorn</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb-19th 1897</u>		
7. AGE	YEARS <u>38</u>	MONTHS <u>6</u>
	DAYS <u>8</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Shoe worker</u>	11. Total time (years) spent in this occupation _____
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
MOTHER FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis Missouri</u>	
	13. NAME <u>John Dorn</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>	
	15. MAIDEN NAME <u>Katherine Wahlen</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>	
17. INFORMANT (ADDRESS) <u>Mrs May Dorn</u> <u>2745 Madison St</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary</u>	DATE <u>Aug 30th 1935</u>	
19. UNDERTAKER (ADDRESS) <u>Street-Care</u> <u>4608 Natural Bridge</u>		
20. FILED <u>AUG 29 1935</u>	<u>J. A. Bredek</u>	Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 27th 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at 4:10 a.m.

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

Chronic Myocarditis
Arterio-sclerosis
Hydrocephalus
Fracture
Other contributory causes of importance: 930

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) J. A. Bredek M.D.

(Address) St. Louis, Missouri

8/29/35

