

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

Do not use this space.

31317

1. PLACE OF DEATH 1935

791

County.....

Registration District No.....

Township.....

Primary Registration District No. 1003

City *St. Louis* (No. *6428*)

City *St. Louis*

File No.....

Registered No. 8153

2. FULL NAME

Edward Faller

(a) Residence, No. *22nd & Market* St. *Waldorf*

Ward.....
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

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 20, 1935*

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

22. I HEREBY CERTIFY, That I attended deceased from *9/26*, 1935 to *9/20*, 1935

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown*

I last saw *him* alive on *9/25*, 1935. Death is said to have occurred on the date stated above, at *9:50 pm*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *abt 65*

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

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

Carcinoma of lip with metastases Date of onset *1932*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

Other contributory causes of importance: *45*

MOTHER FATHER 13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT *Step by Sister* (ADDRESS) *City St. Louis*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington* DATE *9-27-35*

19. UNDERTAKER *Walker Richters* (ADDRESS) *2009 Antway St*

20. FILED *SEP 27 1935* 19 *J. Brodeck* Registrar.

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *no*

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) *M. H. Battles*, 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.

31
31
22

MISSOURI STATE BOARD OF HEALTH - A PERMANENT RECORD

