

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JAN 13 1935

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

Do not use this space.

41307

1. PLACE OF DEATH

County.....
Township.....
City.....*St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *2854*; M = *Hair* ac)

File No. *10524*
Registered No.
St. Ward)

2. FULL NAME

(a) Residence, No. *2854-M-Hair ac* 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 11-1897*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
38 4 2 1

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

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

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

13. NAME *Wm Massmann*

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

15. MAIDEN NAME *Unkenow*

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

17. INFORMANT (ADDRESS) *Martha Massmann 2854-M-Hair ac*

18. BURIAL, CREMATION, OR REMOVAL PLACE *New St Marcus* DATE *Dec 16* 19*35*

19. UNDERTAKER (ADDRESS) *Wacker-Helderte 2331-1/2 Broadway*

20. FILED *13* 19*35* *JT Brebeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 12* 19*35*

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at *440* m.

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

Pulmonary tuberculosis
Ch. Bronchitis
Ch. Cavitation
Other contributory causes of importance: *23*

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) *Harold J. ...* M. D.

(Address) *Deppe*

