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.

AUG 18 1936

791

1. PLACE OF DEATH

County ..... Registration District No. 1003

Township ..... Primary Registration District No. .....

City St. Louis (No. City Hospital No. 1 St. ..... Ward)

File No. 28848

Registered No. 7616

R. 5955

2. FULL NAME Jos Kolb

(a) Residence, No. 2703 a Allen St., 23 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 Edna Kolb

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 24, 1891

7. AGE: Years 46 | Months 10 | Days 23 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. milk driver

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Pevely Dairy

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) Mt. Carmel, Illinois

FATHER

13. NAME Lawrence Kolb

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER

15. MAIDEN NAME Mary Raef

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Hosp. Info. H. H. Kent
(ADDRESS) City Hospital No. 1

18. BURIAL, CREMATION, OR REMOVAL
PLACE Memorial Park Cem DATE 7-20-36, 19

19. UNDERTAKER E. J. Schnur
(ADDRESS) 3125 Lafayette

20. FILED JUL 19 1936 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/17/36, 19

22. I HEREBY CERTIFY, That I attended deceased from 7/17/36, 19, to 7/17/36, 19. I last saw him alive on 7/17/36, 19. Death is said to have occurred on the date stated above, at 10:50 a.m. The principal cause of death and related causes of importance were as follows:

Syphilitic Aortitis — Date of onset

Other contributory causes of importance: 24

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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) Charles T. Farrington, M. D.

(Address) City Hospital No. 1