APR 9 1937

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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City ..... (No. City Hospital # 1, St. ..... Ward)

File No. 10682

Registered No. 3256

2. FULL NAME John Filbar

(a) Residence. No. 5400 S. Lever St., 15 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*): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Unk

7. AGE: Years — Months ✓ Days ✓ If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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

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

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) Germany

FATHER

13. NAME Unk

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

MOTHER

15. MAIDEN NAME Unk

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

17. INFORMANT (ADDRESS) City Hospital # 1 Mildred Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE St Louis DATE 3-1 1937

19. UNDERTAKER (ADDRESS) Wm Ruetter 3500 Potomac St

20. FILED MAR 25 1937 19 J. F. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

No Physician in attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/10 1937

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

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 10 A.M.

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

	Date of onset
Cerebral Apoplexy	

Other contributory causes of importance:

Arteriosclerosis

Name of operation ..... Date of ..... No

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? No
If so, specify

(Signed) Joseph M. Freeman, M.D.
(Address) Deputy Coroner

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.