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

Do not use this space.

24995

File No. 7164

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St. Louis Mo. (No. ..... Sanitarium ..... St. ..... Ward)

2. FULL NAME James Fleck

(a) Residence. No. 4511 Alaska Ave. 13 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	white	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 9. 1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	41	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dry cleaners

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer "

9. BIRTHPLACE (CITY OR TOWN) Aurora

(STATE OR COUNTRY) Indiana

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) "
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) "
(STATE OR COUNTRY)

14. INFORMANT E. R. Summers

(Address) 5300 Arsenal

15. FILED ..... 19..

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 16th 1930

17. I HEREBY CERTIFY, That I attended deceased from June 13th, 1930, to July 16th, 1930, that I last saw him alive on July 15th, 1930, and that death occurred, on the date stated above, at 4:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis of the Insane

0 2
3 4

CONTRIBUTORY (SECONDARY) (Syphilis) (duration) yrs. 6 mos. 4 ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) E. R. Summers, M. D.

7-16, 1930 (Address) 5300 Arsenal

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. Paul's Churchyard	7-19, 1930
20. UNDERTAKER Fr. Schumacher	ADDRESS 3013 Metairie

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.