

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

Do not use this space.

6216

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **1397**

City **St. Louis Mo** (No. **2055 Blenden Pl**)

St.

Ward)

2. FULL NAME

(a) Residence. No.
(Usual place of abode)

St. **4** 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

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

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

Mar 28 1841

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

85

1

8

8. OCCUPATION OF DECEASED

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

Retired

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

Medical Doctor

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN; STATE OR COUNTRY)

Huntingburg Ind

10. NAME OF FATHER

Wm. Kessel

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

Unknown

12. MAIDEN NAME OF MOTHER

Kath. Kliz Othing

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

Unknown

14.

INFORMANT

(Address) -

*Sophia Winkler
2055 Blenden Pl*

15.

FEB -9 1927

FILED

Max C. Starckoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Feb. 6 1927

17.

I HEREBY CERTIFY, That I attended deceased from *Feb. 5*, 19*26*, to *Feb 6*, 19*26*, that I last saw him alive on *Feb 6*, 19*26*, and that death occurred, on the date stated above, at *1:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Stroke

87.5 74 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Arterial Sclerosis

Arteriosclerosis (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 Symptoms*

(Signed) *H. H. Melius*, M. D.

18, 19*27* (Address) *2201 S. M. Cleveland*

*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

Bellefontaine Cemt

Feb 10 1927

20. UNDERTAKER

ADDRESS

Wm. J. Robert

1905 S. Grand Bl

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.

