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

Do not use this space.

6373

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 1565

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

14972

2. FULL NAME Tom Fudge

(a) Residence. No. 1 Clark St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14th 1851

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	11	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 93 A
(c) Name of employer: 9 C

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

PARENTS

10. NAME OF FATHER: Tim Fudge
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tennessee
12. MAIDEN NAME OF MOTHER: Lethie Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

14. INFORMANT: E Roman
(Address) City Hospital

15. FILED FEB 15 1927 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 12 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1927 to Feb 12, 1927 that I last saw him alive on Feb 12 1927 and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chr. Myocarditis infective gangrene of left leg from thrombophlebitis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) (duration) ..... yrs. ..... mos. ..... ds.

90 B

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) S. Shaizer, M. D.
2/13, 1927 (Address) City Hospital

*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: Priedene
DATE OF BURIAL: Feb 16th 1927

20. UNDERTAKER: Math Hermann & Son 4103 W Florissant av
ADDRESS

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.

Judge