

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

Do not use this space.

10003

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. 3536, Henrietta) St. Henrietta Ward

File No.
 Registered No. 2579

2. FULL NAME

Maurice Broccard
 (a) Residence. No. 3536 Henrietta St. 17 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 widower
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
abt. 65 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grocery clerk
 (b) General nature of industry, business, or establishment in which employed (or employer) Thomas Cain
 (c) Name of employer

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

10. NAME OF FATHER Broccard

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. A. C. Mc Nutty
 (Address) 3536 Henrietta

15. FILED 15 1927 Marb. Starsoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 14 - 1927

17. I HEREBY CERTIFY That I attended deceased from Feb 17 1927, to Mar 14 1927 that I last saw h. m. alive on Mar 14 1927, and that death occurred, on the date stated above, at 3:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Interstitial nephritis
104
131 (duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) labar pneumonia
 (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 1010
 IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? Dr. Pfeffer M. D.
 (Signed) _____
 , 19 (Address) Ph. and Bd Olive St.

*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 St. Matthew Cemetery DATE OF BURIAL Mar 17 1927

20. UNDERTAKER Chas. B. 3029 Lafayette Ave ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

V. S. 66. 2. MEDICAL RESERVE FOR BURIAL

