

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

Do not use this space.

13042

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.* (No. *St. Johns Hospital*)

File No. ....

Registered No. **3331**

St. .... Ward

**2. FULL NAME**

(a) Residence No. *3259 Indiana* St., *24* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

**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)

*May 21-1869*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

*57*

*10*

*13*

**8. OCCUPATION OF DECEASED**

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

*Motorman*

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

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

*Missouri*

**10. NAME OF FATHER**

*Unknown*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Missouri*

**12. MAIDEN NAME OF MOTHER**

*Elizabeth Paul*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Unknown*

PARENTS

14.

INFORMANT

(Address)

*Elizabeth Murray  
3259 Indiana Ave.*

15.

FILED

*APR -6 1927*

19

*Max B Starckoff*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

*April 4-1927*

17.

I HEREBY CERTIFY, That I attended deceased from *Mar 1*, 1927, to *April 4*, 1927 that I last saw *him* alive on *April 4*, 1927, and that death occurred, on the date stated above, at *10:25 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*510 Carcinoma of Prostate gland*

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1) DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *Mar 31-27*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

*Robert Hylant, M.D.*

*4/5*, 1927 (Address) *3901 Parkman*

\*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

*Sunset Burial Ph. April 7-1927*

20. UNDERTAKER

ADDRESS

*Ziegenhain Bros 2623 Cherokee*

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.

