

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

Do not use this space.

23031

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.....

Township.....

Primary Registration District No. **1003**

Registered No. **6713**

City **St. Louis** (No. **1001**)

St. **133d** Ward

Ward.....

2. FULL NAME

(a) Residence, No. **133d** **Merchants** **22** Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **40** 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 **widowed**
(write the word)

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

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

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.
Abt 72

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Shopkeeper**
(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) **Germany**

10. NAME OF FATHER

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 (Address) **Dr. [Name] City [Name]**

15. FILED **JUL 24 1927** **Max B. Harkness** REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 23 1927**

17. I HEREBY CERTIFY, That I attended deceased from **July 23 1927** to **July 23 1927**, and that I last saw him alive on **July 23 1927**, and that death occurred, on the date stated above, at **7:30 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
131
930

CONTRIBUTORY (SECONDARY) **Chronic Latent Nephritis**
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **129a**
IF NOT AT PLACE OF BIRTH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....

19. WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) **John [Name] M.D.**
7/23/27 (Address) **City [Name]**

*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 **New St. Marcus Cemetery** DATE OF BURIAL **7/25 1927**

20. UNDERTAKER **Adolph Meyer & Co.** ADDRESS **603 Park Ave**

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.

RECORD

Van Hahn