

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

Do not use this space.

28345

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No.

Registered No. **7858**

2. FULL NAME

Frank (Dato) Dobos

(a) Residence. No. *4650 McKee St* Ward.

(Usual place of abode)

(if nonresident give city or town and State)

Length of residence in city or town where death occurred *22* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male White Married

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

Blanchey Dobos

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *SEP 2 - 1884*

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, <u> </u> hrs. or <u> </u> min.
<i>41</i>	<i>7</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Life Insurance*
 (b) General nature of industry, business, or establishment in which employed (or employer) *High (Brit)*
 (c) Name of employer *American Nat'l Ins Co.*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Australia*

PARENTS

10. NAME OF FATHER *Joe Dato*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Mona Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

14.

INFORMANT *E. Kenna*
(Address) *City Hospital*

15.

FILED *SEP - 3 10 1919* mar. C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 27 1919*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 21 1919* to *Sept 27 1919*

that I last saw him alive on *Sept 27 1919*, and that death occurred, on the date stated above, at *350* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23H Pulmonary Tuberculosis far advanced

CONTRIBUTOR (SECONDARY)

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) *John H. ...* M. D.

(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

DATE OF BURIAL

New St. Marcus Cem.

Sept 4 1919

20. UNDERTAKER

ADDRESS

City Bros.

3029 Lafayette

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.

data.