

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

Do not use this space.

2555

1. PLACE OF DEATH

County.....

Registration District No. 791

File No. 106

Township.....

Primary Registration District No. 1003

Registered No. 106

City St. Louis (No. 182 H)

St. 7 Ward

St. Ward)

2. FULL NAME

(a) Residence. No. 310 Convent St. 12 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of Margaret Garbs

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12 - 1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hra. ormin.
	<u>70</u>	<u>7</u>	<u>22</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER Peter Garbs

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Edna Fuchler
(Address) 1822 - S 7th St

15. J.A.H. FILED 4 1923 mae Staroff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1928

17. I HEREBY CERTIFY That I attended deceased from May 10 1925 to Jan 3 1928 that I last saw him alive on Jan 1 1928, and that death occurred, on the date stated above, at 11:50 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chrom Myocarditis
93C
100 B (duration) yrs. mos. da.
CONTRIBUTORY Chrom Bronchitis non
Tubercular (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH W B

19. DID AN OPERATION PRECEDE DEATH 7 DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) William Dinko, M. D.
1/3 28, 19 (Address) 1321 S. Broadway

*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 DATE OF BURIAL 19

20. UNDERTAKER Wacker-Holderle ADDRESS 2331 - S Broadway

WHITE PAPER, WITH UNFADING INK--THIS IS A PERMANENT RECORD

K. 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.

IN RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 791 File No.
Township..... Primary Registration District No. 1273 Registered No. 106
City St. Louis No. St. Ward)

2. FULL NAME John Garba

(a) Residence. No. St. Ward.
(Usual place of abode) (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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

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)

15.

FILED 112 26 1928

Wm. C. Stankley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 19 28
17.

I HEREBY CERTIFY, That I attended deceased from
....., 19....., to 19.....
that I last saw h..... prior to 19....., and that
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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)....., M. D.
, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

114 19 28

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UN
STATEMENT OF OCCUPATION is ver
PHYSICIANS
EXACTLY.
AGs sho
carefully supplied.
AGs sho
in plain terms,
so that it may be properly classified.
F
RE COMPLETE AS PRESCRIBE
N. 1
CAUSE
WRITE PLAINLY, WITH UNFADING
item of information should be carefully supplied. AGs sho
in plain terms, so that it may be properly classified. F

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