

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

Do not use this space.

10633

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. **2376**

Registered No. **2376**

St. Ward)

2. FULL NAME

(a) Residence. No. **3213 Market**, **18** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **20** 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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 15 1883**

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	44	5	16	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) **Romania**

10. NAME OF FATHER **Toney Crusan**

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY) **Romania**

12. MAIDEN NAME OF MOTHER **Dora Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN, STATE OR COUNTRY) **Romania**

14. INFORMANT (Address) **City Hospital**

15. FILED **Mar 6 1923** **Mar 6 Starceff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 19 1923**

17. I HEREBY CERTIFY That I attended deceased from **Jan 19**, 19**23**, to **March 19**, 19**23**, that I last saw him alive on **March 19**, 19**23**, and that death occurred, on the date stated above, at **7:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic pulmonary tuberculosis
2.3A

CONTRIBUTORY (SECONDARY) **31** (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Henry C. Westerman** M.D.

, 19**23** (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

Mount Hope Cemetery Mar 31

20. UNDERTAKER ADDRESS

Hendouelle 6203 Grand

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.

Omson