

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

Do not use this space.

10720

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**
(No. **5048A**, **Beason Ave**)

File No.....
Registered No. **2531**
St. Ward)

2. FULL NAME

Walter H. Doerr Jr.

(a) Residence. No. **5048 Beason Ave**, St. **7** 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 *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) *Feb. 27 - 1928*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— — 8

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Walter H. Doerr Sr.*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Sullivan Magenthal*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo*

14. INFORMANT *Walter H. Doerr Sr.*
(Address) *5048 Beason Ave*

15. FILED *May 6 1928*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/6* 19*28*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 27* 19*28*, to *Mar 6* 19*28* that I last saw him alive on *Mar 5* 19*28*, and that death occurred, on the date stated above, at *6:43* A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia
Secondary
(duration) yrs. mos. ds.

CONTRIBUTORY *This child had only 1 kidney -*
(SECONDARY) *Conjunctival Intestinal adhesion*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? *107th*
IF NOT AT PLACE OF BIRTH? *107th*

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Cutopsy*
(Signed) *Matthew W. Ellis*, M. D.
, 19 (Address) *1005 1/2 Melrose*

*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 *Galveston Cemetery* DATE OF BURIAL *Mar. 7 - 1928*

20. UNDERTAKER *Goodhart & Goodhart*
and Co ADDRESS *2228 St. Louis Ave*

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.

