

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

Do not use this space.

**1. PLACE OF DEATH**

County *St. Louis Mo*  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**

File No. **19372**  
Registered No. **5812**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *3800 Cass St.* St. *13* Ward.

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widower*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *9-10-1866*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*61 8 2*

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) *Missouri* (STATE OR COUNTRY)

10. NAME OF FATHER *Edg Poag*

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

12. MAIDEN NAME OF MOTHER *Anne Bigley*

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

14. INFORMANT *Mrs M Epinger* (Address) *5800 Cass St*

15. FILED *APR 29 1923* *Max C. Stanley* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 12 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Apr 29* 19*28*, to *May 12* 19*28* that I last saw him alive on *May 12* 19*28*, and that death occurred, on the date stated above, at *5:20* p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Methyl Alcohol Poisoning*  
*103 X*  
*75 B* (duration) yrs. mos. da.

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *R. Berg* M. D.

(Signed) *R. Berg* 19 (Address) *5800 Cass St.*

\*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 *St. Louis* DATE OF BURIAL *5/15 28*

20. UNDERTAKER *W. Richter 3500 Rutger* ADDRESS

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.

WHERE PENALTY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

ACTIVATION

CONFIDENTIAL - SECURITY INFORMATION

**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. 291 File No.....  
 Townsh. St. Louis Primary Registration District No. 1003 Registered No. 3817  
 City..... (No.....) St. .... Ward.....

**2. FULL NAME**

(a) Residence. No. John Poag 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) wid

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  
 (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 14 1925 May 14 1925

*May e Starker*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 1925

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Metaph alcohol poisoning chronic alcoholism, Suffocation given over phone by Dr. R. Berg*  
 CONTRIBUTORY (SECONDARY) Wid. of W. d. 7-12-25  
 (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) R. Berg M. D.

, 19 (Address) 5840 Franklin

\*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

INK---THIS IS A PERI

N. B.— CAUSE (F. REGISTRARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. ately supplied. AGE should be stated EXACTLY. PHYSICIAN. hat it may be properly classified. Exact statement of OCCUPATION is very important.

**SUPPLEMENTARY**

S-1937a