

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

Do not use this space.

34887
File No. 9851
Registered No. _____
St. _____ Ward)

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo** (No. **Josephine Hosp**)

2. FULL NAME

John H. Becker
(a) Residence (Usual place of abode) No. **24 S. 8th St.** St. **15** 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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 26-1871**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 5 8

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

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

10. NAME OF FATHER **John Becker**

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

12. MAIDEN NAME OF MOTHER **Anna Sout know**

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

14. INFORMANT **Mary Becker**
(Address) **24 S. 8th St.**

15. FILED **7-1-28** **May 6 Starckoff**
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 4th 1928**

17. I HEREBY CERTIFY That I attended deceased from **Aug 17** 1928 to **Oct 4** 1928 that I last saw him alive on **Oct 4** 1928, and that death occurred, on the date stated above, at **9:40 PM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Bright's Disease
130
132B

(duration) yrs. **4** mos. da.
CONTRIBUTORY **Uremia**
(SECONDARY) (duration) yrs. mos. da. **6**

18. WHERE WAS DISEASE CONTRACTED **26 S 8th**
IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....
no

WHAT TEST CONFIRMED DIAGNOSIS: **Urimy**
(Signed) **W. S. Saubrey** M. D.
Oct 6 1928 (Address) **3758 Lafayette**

*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 **Memorial Park's** DATE OF BURIAL **Oct 8 1928**

20. UNDERTAKER **By Leidner And Co** ADDRESS **1417 N. Market St.**

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.

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U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
OFFICE OF THE DIRECTOR
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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

Registration District No.....
Primary Registration District No.....

File No.....
Registered No. *9851*
St. Ward)

2. FULL NAME

John H. Becker
(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.....
(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 7 1928

Max C. Stankiewicz
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 4 - 19 28*

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Acute Bright's Disease
Cause unknown, Information
given over Phone by Dr. W.
Detlevsky, Dir. of Dist. H. 3-28
Wentz*

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

WITH UNFADING

WITH UNFADING

N. B. This certificate should be carefully supplied. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Births and deaths of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-34887