

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

Do not use this space.

12150

1929

1. PLACE OF DEATH

County St. Louis
Towship Central
City St. Charles

Registration District No. 789
Primary Registration District No. 6033 B
(No. 7817 St. Charles R.R.)

File No. _____
Registered No. 83
St. _____ Ward _____

2. FULL NAME Paul O. Alsheben

(a) Residence. No. 7817 St. Charles R.R. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 19 29

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

I HEREBY CERTIFY, That I attended deceased from 3-4 to 3-6 1929 that I last saw him alive on 3-6 1929, and that death occurred, on the date stated above, at 8:10 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 19 1880

THE CAUSE OF DEATH* WAS AS FOLLOWS:

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than I day, hrs. or min. |
|--------|-----------|-----------|-----------|----------------------------------|
| | <u>48</u> | <u>10</u> | <u>17</u> | <u>15</u> |

10 Robor Pneumonia
11 Left
(duration) yrs. mos. ds. 3

8. OCCUPATION OF DECEASED

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

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Germany

18. WHERE WAS DISEASE CONTRACTED 10/10
IF NOT AT PLACE OF DEATH _____

10. NAME OF FATHER Andrew Alsheben

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

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

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Ch. A. Potts, M. D.

12. MAIDEN NAME OF MOTHER _____

3-7, 1929 (Address) 6118 Easton

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

*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.

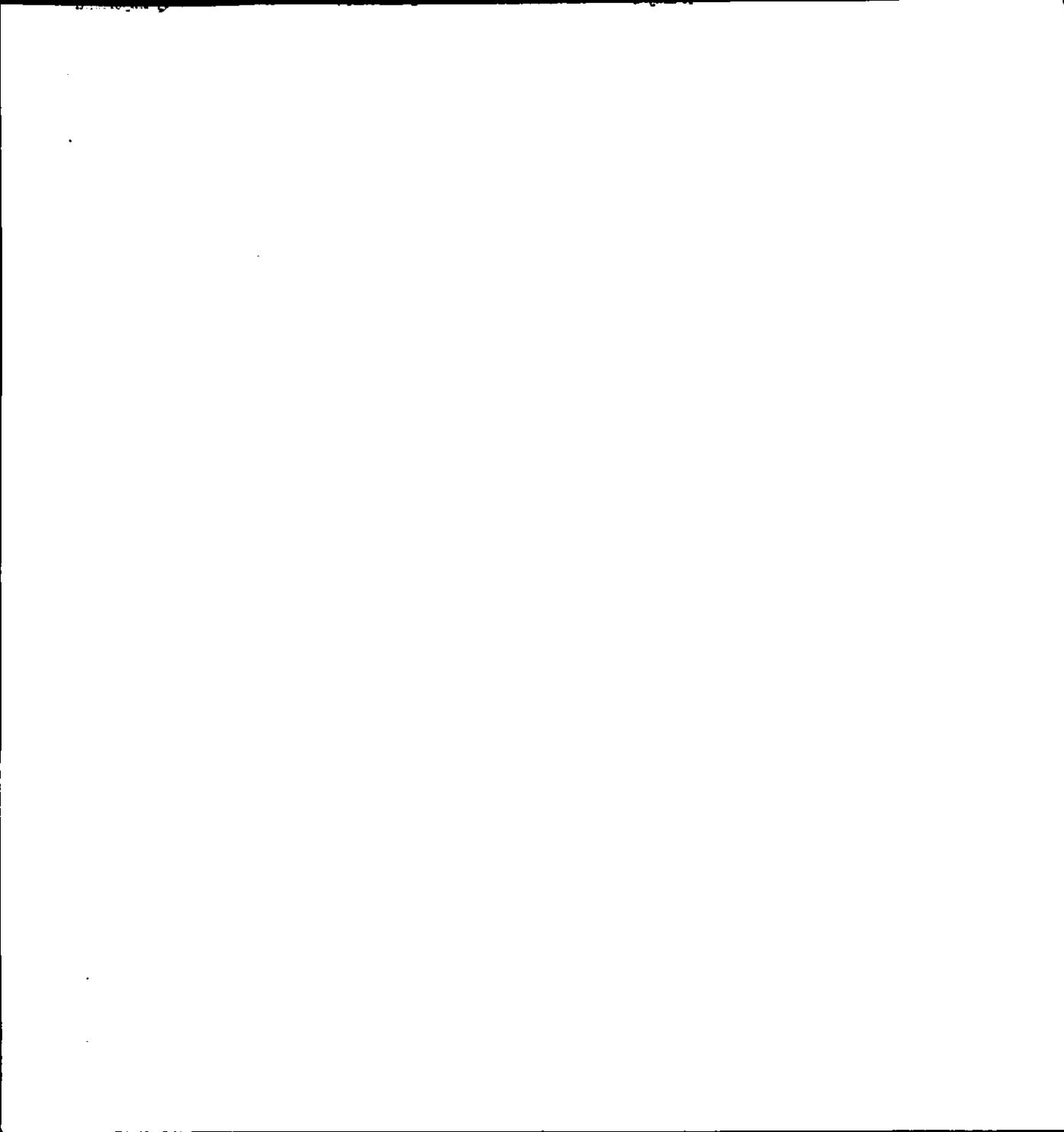
14. INFORMANT Mrs. Mary Alsheben
(Address) 7817 St. Charles R.R.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Mausoleum DATE OF BURIAL 3-9 1929

15. FILED 3/8 1929 Reed Tracy M.D. REGISTRAR

20. UNDERTAKER Geo. L. Pleitsch ADDRESS 5966 Easton

247
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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 St. Louis
Township Central
City..... (No..... St..... Ward)

Registration District No. 789
Primary Registration District No. 6033 B

File No.....
Registered No. 83

2. FULL NAME

Paul D. Alsteborn

(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 St. Louis

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

14. INFORMANT..... (Address)

15. FILED 3/29 1929 Rolls Bruce M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 6 1929

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:

..... (duration) yrs. mos. ds.
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

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12150