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

Do not use this space.

File No. 12377

Registered No. 2897

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. Barnes Hospital St. ..... Ward)

2. FULL NAME Harry Walter Gass

(a) Residence. No. 6518 Odell Ave. St., 3 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 18th, 1882.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
46	6	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Millwright

(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) Pennsylvania

PARENTS

10. NAME OF FATHER John Gass

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

12. MAIDEN NAME OF MOTHER Margaret Young

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

14. INFORMANT Williard Gass
(Address) 6518 Odell Ave.

15. FILED Mar 6 1929 19 Mary C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March, 5th. 19 29

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 7.25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Rupture of Aneurysm of Arch of Aorta (Non traumatic)

(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? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. M. Beardsley M.D. (Dr. D.)
3/6 , 19 29 (Address) Coroners Office

*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 New St. Marcus — DATE OF BURIAL Mar. 7- 19 29

20. UNDERTAKER Wacker Heldele — ADDRESS 2314 So Broadway

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.