

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

Do not use this space.

12863

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No.....

Registered No. **3408**

St. **1** Ward

**2. FULL NAME**

(a) Residence. No. **Madison** St., **23** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **40** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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) **March 23 - 1877**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**56 | 3 | 9**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Laborer**  
(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) **Missouri**

10. NAME OF FATHER **Frank**

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

12. MAIDEN NAME OF MOTHER **Frank**

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

14. INFORMANT (Address) **Walter Richter**

15. FILED **MAR 19 1929** REGISTRAR

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 4 1929**

17. I HEREBY CERTIFY That I attended deceased from **March 3**, 19**29**, to **March 4**, 19**29**, that I last saw him alive on **March 4**, 19**29**, and that death occurred, on the date stated above, at **St. Louis**.

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

**Lobar Pneumonia**

CONTRIBUTORY (SECONDARY) **1010**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **R. Berg**, M. D. **3/4**, 19**29** (Address) **City of St. Louis**

\*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. **Removed to Washalla Cem. 3-26-29**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St. Louis U.** DATE OF BURIAL **3-13 1929**

20. UNDERTAKER **Walter Richter** ADDRESS **3500 Rutger 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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