

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

Do not use this space.

22972

1. PLACE OF DEATH

County.....
Township.....
City St Louis

Registration District No. 791
Primary Registration District No. 1003
(No. 4641 Nebraska Ave.)

File No.....
Registered No. 6398
St..... Ward.....

2. FULL NAME

August H. Quest

(a) Residence No. 4641 Nebraska St., 15 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 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

Emilie Quest

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 11 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Wm Quest

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Emilie Quest
(Address) 4641 Nebraska Ave

15. FILED JUN 14 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-11 1929

17. I HEREBY CERTIFY, That I attended deceased from June 4th 1929, to June 11th 1929 that I last saw him alive on June 11th 1929, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterial hemorrhage (of apoplexy)
(duration) yrs. mos. ds.

CONTRIBUTORY chronic myelitic hypertension
(SECONDARY) Unknown (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH Unknown

DID AN OPERATION PRECEDE DEATH? No. DATE OF -
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Bronard Block, M. D.

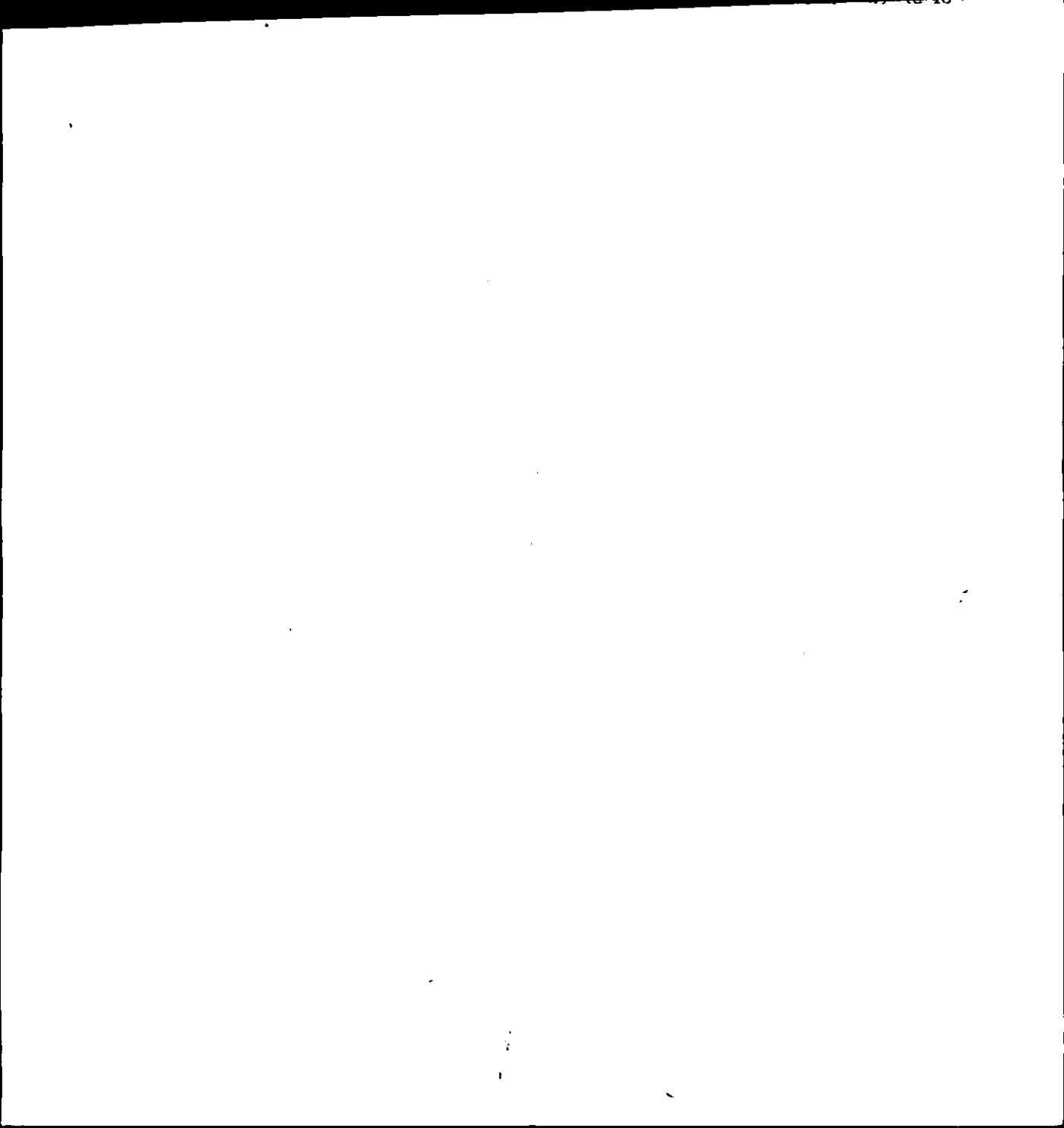
19 (Address) 3527 Proge St. Louis Mo

*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 Our Redeemer Cem. DATE OF BURIAL June 14 1929

20. UNDERTAKER Ther. H. Biederwieden ADDRESS 1936 St. Louis

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

ALL INFORMATION REQUESTED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. **6398**
 City..... (No. **4641 Nebraska**) St. Ward)

2. FULL NAME

August H. Quest

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 23 - 1860*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
66 7 19

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 *Elmer F. Quast*
 (Address) *4641 Nebraska*

15. JUN 18 1929
 FILED 19 *Wm C Stankov*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6 - 11 - 1929*

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

SUPPLEMENTARY

5-22972