

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

Do not use this space.

32612

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City..... (No. **3755**) **Ferry**

File No.....  
Registered No. **9734**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **3753** **Ferry** St., **11** 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) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
<b>abk 51</b>				

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. **Engineer 1042**  
(b) General nature of industry, business, or establishment in which employed (or employer) **Engineer**  
(c) Name of employer **Reynolds**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

**PARENTS**  
10. NAME OF FATHER **Not known**  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Not known**  
12. MAIDEN NAME OF MOTHER **Not known**  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

14. INFORMANT **Courts Brostrom**  
(Address) **Police department**

15. **NOT FILED** **1924**  
**Max G. Starckloff**  
**Brostrom** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 30 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..... **6:45 A** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Asphyxiation, deep to fuel gas poisoning, self-administered**  
(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) **Suicide**  
(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED? **1042**  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF.....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
Signed) **J. W. Kessner**, M.D.  
**10/2, 1929** (Address) **Dep. Comm**

\*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 **St. Matthews Cem** DATE OF BURIAL **Oct 4 1929**

20. UNDERTAKER **Philander Craig** ADDRESS **4468 W. 11th 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.

222  
31

