

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

Do not use this space.

1. PLACE OF DEATH

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

Registration District No. **701**
1003

File No. **42143**
Registered No. **11850**
St. Ward)

2. FULL NAME

(a) Residence. No. *415 423 N. Broadway* Ward. *9*
(Usual place of abode)

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. MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 18, 1900*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
19 6 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Day Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis, Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Arnold Bendorf*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT *Mrs. Adelaide Bendorf*
(Address) *5423 N. Broadway*

15. FILED *5-19-29* *May C Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at *7³⁰ P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxiation due to Fuel Gas Poisoning
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *While suffering from temporary mental aberration*

18. WHERE WAS DISEASE CONTRACTED *St. Louis, Mo. Suicidal*

IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. W. Kermer* M. D.
1215 29th St. St. Louis, Mo. (Address) *Dep. Coroner*

*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. Johns (Cath)* DATE OF BURIAL *Dec 7 1929*

20. UNDERTAKER *Math. Hermann* ADDRESS *216 E. Farr An.*

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.

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

277
1
2
10

