

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

Do not use this space.

28034

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City Hospital)

File No.....

Registered No. 7863

St. Ward)

2. FULL NAME

(a) Residence. No. 5827 Woodland 7 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 65 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 (If the word)

male white Widowed

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

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

Not Known

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

About 86

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) all kinds
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Germany

10. NAME OF FATHER

Unknown Schreiber

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

14.

INFORMANT

(Address) City Hospital

15. AUG -7 1930

FILED

Max C. Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Aug 6 1930

I HEREBY CERTIFY That I attended deceased from July 30, 1930, to Aug 6, 1930, that I last saw him alive on Aug 6, 1930, and that death occurred, on the date stated above, at City Hospital

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11 1/2 Asthma (non-tubercular)
11 1/2

CONTRIBUTORY (SECONDARY)

Hypostatic Pneumonia
103 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH no

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical
(Signed) Raymond Jacobs, M. D.
86 . 150 (Address) City Hospital

*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

Memorial Park Aug 8 1930

20. UNDERTAKER

ADDRESS

Math Herincum Box 2/61 Paris

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.

Schreibes