

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

Do not use this space.

1. PLACE OF DEATH

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

Registration District No. 797
Primary Registration District No. 1003
(No. 3303 No Broadway)

File No. 28233
Registered No. 8078
St. _____ Ward _____

2. FULL NAME

Edward Dreyer
(a) Residence. No. 3303 N. Broadway St. 26 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 single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 7 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 11 2

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

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

10. NAME OF FATHER Herman Dreyer

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

12. MAIDEN NAME OF MOTHER Elizabeth Hummel

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

14. INFORMANT Henry Dreyer
(Address) 3303 No Broadway

15. FILED AUG 12 1930 Wm C. Starnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 - 1930

17. I HEREBY CERTIFY, That I attended deceased from July 10th, 1930 to Aug 9th, 1930 that I last saw him alive on Aug 2nd, 1930, and that death occurred, on the date stated above at St. Louis.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis
97 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 7/10
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMS DIAGNOSIS Cerebral
(Signed) A. H. Smith M. D.
, 19 _____ (Address) 15850 Highland

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Celovany Cemetery DATE OF BURIAL Aug 13 1930

20. UNDERTAKER Stout Carroll ADDRESS 4500 N. 1st 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.

12