

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

Do not use this space.

40839

File No. _____
Registered No. **11482**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. **781**
City **St. Louis, Mo.** (No. **City Hospital # 1003**) St. _____ Ward _____

2. FULL NAME George Bretz

(a) Residence. No. **3159 Bent Avenue** St. **16** Ward _____
(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. (If nonresident, give city or town and State)

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 **Sarah Bretz**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 13, 1896**

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	34	8	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Tool & Die Maker**
(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) **Rumania**

10. NAME OF FATHER **George Bretz**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Rumania**
12. MAIDEN NAME OF MOTHER **Unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Rumania**

14. INFORMANT **Sarah Bretz**
(Address) **3159 Bent Avenue**

15. FILED **12-8-30** **Max C. Starbuck** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **December 6, 1930**

17. *No Physician in attendance.*
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 **5:00** P. _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain Abscess
1048
78A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Perforated frontal sinus** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Cause unknown**

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) **[Signature]** M.D.

12/8/30 (Address) **Deputy Coroner**

*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 **Chicago, Illinois** DATE OF BURIAL **Dec. 8, 1930**

20. UNDERTAKER **Wacker-Heldrich** ADDRESS **2551 S. Brdwy.**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Cause of death should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important.

