

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

Do not use this space.

40976

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1002**
 City **St. Louis** (No. **On route City Hospital #1**) St. Ward)

File No.
 Registered No. **11536**

2. FULL NAME

(a) Residence. No. **2700 S Broadway St.** **23** 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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 15 - 1872**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
About 58	3	3	25	

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

9. BIRTHPLACE (CITY OR TOWN)..... **Germany**
 (STATE OR COUNTRY)

10. NAME OF FATHER **John Barteska**

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

12. MAIDEN NAME OF MOTHER **Unkeno**

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

14. INFORMANT **Roy E. Chisholm**
 (Address) **4932-70 Union Bl**

15. FILED **12 13 1930** REGISTER

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 10 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 **12:15 p. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ruptured Aneurysm of Left
Spinal Artery (non-traumatic)
96 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **91W** (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **J. W. Kerner, M.D.**

12/12 1930 (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 **Valhalla** DATE OF BURIAL **Dec 13 1930**

20. UNDERTAKER **Wacker-Helderte** ADDRESS **2331 S. Edway**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

