

MAY 25 1934

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

Do not use this space.

1. PLACE OF DEATH

County St. CharlesRegistration District No. 757Township St. CharlesPrimary Registration District No. 2036City St. Charles (No. 1030)WashingtonFile No. 13982Registered No. 50St. 2nd Ward

2. FULL NAME

(a) Residence, No. 1030 Washington St., 2nd Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ella May Fols6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 11, 18897. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
44 8 298. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Anywhere10. Date deceased last worked at this occupation (month and year) March, 1934 11. Total time (years) spent in this occupation. 25 yrs12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles, Mo.13. NAME Oscar Fols14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known15. MAIDEN NAME Sarah Ricks16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known17. INFORMANT (ADDRESS) Mrs. Ella May Fols
1030 Washington St.18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cem DATE April 12, 193419. UNDERTAKER (ADDRESS) Steinbrinners
St. Charles, Mo.20. FILED 7/12 1934 Wm. H. Fols

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 10, 193422. I HEREBY CERTIFY, That I attended deceased from April 3, 1934 to April 10, 1934Last saw him alive on April 10, 1934. Death is said to have occurred on the date stated above, at 3:40 A.M.

The principal cause of death and related causes of importance were as follows:

Date of onset

Pneumonia100 ✓

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

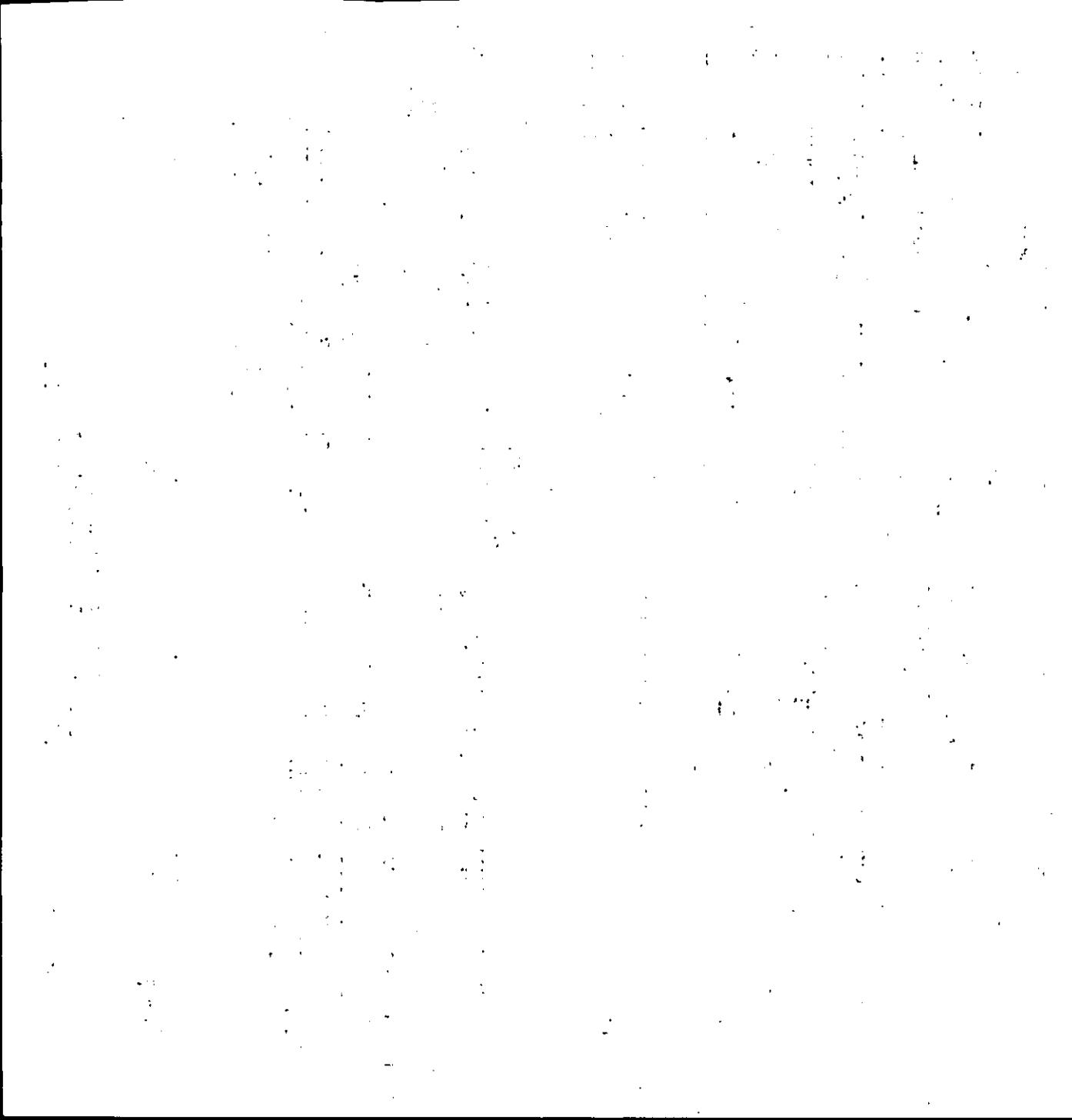
Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.

(Signed) Wm. H. Fols M. D.(Address) 10 Washington St. St. Charles, Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Charles Registration District No. 757
 Township St. Charles Primary Registration District No. 3036
 City St. Charles (No. _____) St. _____ Ward _____

2. FULL NAME Walter Fala
 (a) Residence, No. _____ St. _____ 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 m 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 (write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED _____ 19 _____ Clarence J. Wessler
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 10 1934

22. I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Postoperative Labor (Trauma)
 Date of onset _____

Other contributory causes of importance:
100

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

(Signed) [Signature] M. D.
 (Address) 10 [Address]

SUPPLEMENTARY

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S-13982