

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.

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

5163
 Do not use this space.

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No..... **1856**
 (c) City St. Louis, Mo. (d) Street No. 9 SOLATION Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 53 yrs. 10 mos. 23 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Witzel
 (a) Residence, No. 2710 N. 19th St St. 26 (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** WIDOWER
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 2-1885

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	53	10	23	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. COOK
9. Industry or business in which work was done, as 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) MISSOURI

FATHER
13. NAME Adam Witzel
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

MOTHER
15. MAIDEN NAME EVA ?
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

17. INFORMANT A. J. LANE
 (ADDRESS) 5600 ARSENAL

18. BURIAL, CREMATION, OR REMOVAL PLACE FRIEDENS CEM DATE FEB 27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. Budick and Co. 1417 N. Market St.

20. FILED FEB 27 1939 J. D. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-25 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-10-39, 19... to 2-25-39, 19...
 I last saw him alive on 2-25-39, 19... Death is said to have occurred on the date stated above, at 1:30 A.M.
 The principal cause of death and related causes of importance were as follows:

Pulmonary tuberculosis, bilaterally, far advanced
Cachexia

Date of onset

Other contributory causes of importance:
Airrhosis of liver, early

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? yes

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? 1
 If so, specify Pulmonary
 (Signed) P. W. Maxwell, M. D.
 (Address)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,* or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 1/2 Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.