REC'D APR 12 1939

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

791

8754
Do not use this space.

1. PLACE OF DEATH
(a) County
(b) Township
(c) City St. Louis
Registration District No. 1003
Primary Registration District No.
Registered No. 2519
(d) Street No. City Hospital No. 1 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 11646

2. PRINT FULL NAME 640 August Voirol
(a) Residence, No. No Home St. X
(Usual place of abode, if no street address, write county or city) (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): single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 14, 1860

7. AGE: Years 78 | Months 10 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. nil
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) Switzerland

FATHER
13. NAME Gus Voirol
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

MOTHER
15. MAIDEN NAME Mary ?
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

17. INFORMANT (ADDRESS) Hosp. Info L. Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE 3/17, 1939

19. FUNERAL DIRECTOR (NAME) J. H. Gebhardt & Co.
(ADDRESS) 2842 Gravois

20. FILED MAR 16 1939, 19
J. F. Bausch
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/3/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 11/8/38, 19..., to 3/3/39, 19...
I last saw him alive on 3/3/39, 19... Death is said to have occurred on the date stated above, at 7.20 a.m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of Stomach — Date of onset
Lobar Pneumonia

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? No
If so, specify
(Signed) R. Potashnick, M. D.
(Address) City Hospital No. 1

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY, WITH STANDING INK—THIS IS A PERMANENT RECORD

X14028

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, ...

No Embalming, or by .....,

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.