

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

Do not use this space.

16057

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St Louis (No. City Hospital)

File No. 4086

Registered No. 4086

St. Ward)

2. FULL NAME

Otto Kanke

(a) Residence. No. Nokomis Ill St. 73 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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

Anna Kanke.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 18 1892

7. AGE

YEARS 36

MONTHS 6

DAYS 17

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer Abrolat bond. Co.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bloomington Ill

10. NAME OF FATHER Louis Kanke

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Berlin Prussia

12. MAIDEN NAME OF MOTHER Mehelmina Thormaehlen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Washington Mo

14. INFORMANT Anna Kanke
(Address) Nokomis Ill

15. REGISTAR Ray C. Starker
FILED - 6 1929

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-5-29 19

17. 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 3:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
Fracture Spine
fall from ladder
186A (duration) yrs. mos. da.
1928
CONTRIBUTORY (SECONDARY) accident
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 186A
IF NOT AT PLACE OF DEATH.

18. DID AN OPERATION PRECEDE DEATH. Yes DATE OF.....
WAS THERE AN AUTOPSY. Yes

WHAT TEST CONFIRMED DIAGNOSIS.
(Signed) Frank Dexter, M.D.
4/6, 1929 (Address) Coroner

*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 Mount Olivet Ill **DATE OF BURIAL** April 6 1929

20. UNDERTAKER Theo A. Bidwieder **ADDRESS** 1936 N. Louis Ave.

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.

69
1-10-29

