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

PLACE OF DEATH

County St. Louis

Township Central

or

Village ~~Creve Coeur Inn~~

or

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 7 E 0

Primary Registration District No. 6033

File No. 15822

Registered No. 36

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lucilla F. Conrath

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	White	Single

DATE OF BIRTH Dec. (Month) 17 (Day) 1900 (Year)

AGE ✓ yrs. 3 mos. 14 ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 11-A

BIRTHPLACE (City or town, State or foreign country) Creve Coeur 11-A

PARENTS
NAME OF FATHER Peter Conrath
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Elizabeth Goebel
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Goebel

(ADDRESS) Creve Coeur Mo. Route 2

Filed 4/25 1916. J. B. Sudduth REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April (Month) 1 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from March 31, 1916, to April 1, 1916 that I last saw her alive on March 31, 1916 and that death occurred, on the date stated above, at 3 45 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

11-A

11-A

(Duration) ____ yrs. ____ mos. 3 ds.

Contributory (SECONDARY) Grippe

(Duration) ____ yrs. ____ mos. 3 ds.

(Signed) H. J. Hom M. D.

April 1, 1916 (Address) Creve Coeur

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery St. Louis Mo.	April 2, 1916
UNDERTAKER	**ADDRESS**
G. L. Bannmann	Creve Coeur Mo.

For information should be carefully supplied. CAUSE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County .....

Township .....
or
Village .....
or
City .....

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ..... (Month) ..... (Day) ..... (Year) 191..

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191..

UNDERTAKER | ADDRESS