

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

1 PLACE OF DEATH

County
Township
or
Village
or
City **ST. LOUIS**

Registration District No. **791** File No. **39062**
Primary Registration District No. **1003** Registered No. **10353**
(No. **3433^a Crittenden**, **14** Ward)

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

2 FULL NAME **Yetta Abrams**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed (Write the word)
6 DATE OF BIRTH Jan 13 18 37 (Month) (Day) (Year)		
7 AGE 79 yrs. 10 mos. 28 ds.		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry business or establishment in which employed (or employer) None		
9 BIRTHPLACE (City or town, State or foreign country) Germany		
PARENTS	10 NAME OF FATHER Fred Gumpert	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany	
	12 MAIDEN NAME OF MOTHER Don't know	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany	

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **November 11** 191**6**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from **Nov 8** 191**6** to **Nov 11** 191**6**, that I last saw her alive on **Nov 11** 191**6**, and that death occurred, on the date stated above, at **12⁴⁵** a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

107A (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)..... (Duration).....yrs.....mos.....ds.

(Signed) **Augusta Helle** M. D.
Nov. 11, 1916 (Address) **3525 Arsenal St.**

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

18 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.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Fred Abrams**
(Address) **3433^a Crittenden**

15 Filed **NOV 11 1916** **Mayb Starkloff**
Registrar

19 PLACE OF BURIAL OR REMOVAL **St. Olive Cemetery** DATE OF BURIAL **Nov 12** 191**6**

20 UNDERTAKER **Haas and Co** ADDRESS **765 N. Euclid Ave**

