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

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 ..... Registration District No. 791 File No. 30738

or

Village ..... Primary Registration District No. 1003 Registered No. 8643

or

City St. Louis. (NO. 2400 S. 10th. St.; 9 Ward)

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

2 FULL NAME Julia Gross.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married.

6 DATE OF BIRTH: June (Month) 29th. (Day), 1836. (Year)

7 AGE: 82 yrs. 2 mos. 16 ds.

If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Austria.

PARENTS

10 NAME OF FATHER: John Fiedler

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia Graber

(Address) 2400 S.10th.St'

15 Filed SEP 16 1918, 19 Mau C Starkloff Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 14 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 10, 1918, to Sept 14, 1918, that I last saw her alive on Sept 14, 1918; and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows: Chronic Int. Nephritis

120

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

CONTRIBUTORY (Secondary) .....

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

(Signed) Robert L. Reber M.D.

Sept 16 1918 (Address) 1837 S 9 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 .....

19 PLACE OF BURIAL OR REMOVAL: Ev. Luthern (Carondelet)

DATE OF BURIAL: Sept. 17, 1918

20 UNDERTAKER: Wacker-Helderle

ADDRESS: 2331 S. Bdway

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

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St. ..... Ward)

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

**2 FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH
..... 1.....
(Month) (Day) (Year)

7 AGE
.....yrs. ..... mos. ..... ds.

If LESS than 1 day, .....hrs. or .....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., .....
Registrar

**MEDICAL CERTIFICATE OF DEATH**

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

17 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.

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 .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| | ....., 191..... |
| **20 UNDERTAKER** | **ADDRESS** |

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

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