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. 30888

or

Village ..... Primary Registration District No. 1003 Registered No. 8820

or

City St. Louis, Mo. (NO. Sanitarium St.; W Ward)

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

2 FULL NAME Mary Thekla Mundveller

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: Unknown (Month) (Day) 1 (Year)

7 AGE: About 55 yrs. ..... mos. ..... ds.

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

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

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

PARENTS

10 NAME OF FATHER: Unknown

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

12 MAIDEN NAME OF MOTHER: Unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A C Vickrey

(Address) 5400 Arsenal

15 Filed SEP 22 1918, 191 Mary C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 20 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1918, to September 20, 1918, that I last saw her alive on September 20, 1918, and that death occurred, on the date stated above, at 7:10 p.m.

The CAUSE OF DEATH* was as follows:

83 Demented Paralytica

(Duration) 1 yrs. 11 mos. 29+ ds.

CONTRIBUTORY (Secondary) Aortic-Regurgitation

(Duration) 1 yrs. 11 mos. 29+ ds.

(Signed) A C Vickrey M. D.

Sept 20, 1918 (Address) 5400 Arsenal

*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 1 yrs. 11 mos. 29 ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence 3971 Schiller Pl.

19 PLACE OF BURIAL OR REMOVAL: St. Peter-Pauls

DATE OF BURIAL: Sept 23, 1918

20 UNDERTAKER: Wacker-Helderle

ADDRESS: 2331 So. Berry

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

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.