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

31133

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 781 File No. 9054

or

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

or

City St Louis Mo (No. 2115 N 15th Str St.; 3 Ward)

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

2 FULL NAME Etta Kottmeier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May (Month) 23d (Day) 1893 (Year)

7 AGE: 25 yrs. 4 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): St Louis Mo

PARENTS

10 NAME OF FATHER: Henry Kottmeier

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

12 MAIDEN NAME OF MOTHER: Emma Jasper

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Kottmeier
(Address) 2114 N. 15th St.

15 Filed OCT 1 1918 Mae C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 28 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 22, 1917, to Sept 28, 1918, that I last saw her alive on Sept 27, 1918, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency Uremia
Epi
NA

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

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

(Signed) L. H. Kempelmann M. D.
Oct 1, 1918 (Address) Metropolitan Bldg

*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: St Johns

DATE OF BURIAL: Oct 1st, 1918

20 UNDERTAKER: H. Leibrock Undertaker

ADDRESS: 1417 N. Union Ave

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**

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.

WRITE LEGIBLY, WITH UNFADING INK