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. 701 File No. 35923

or

Village ..... Primary Registration District No. 1002 Registered No. 9270

or

City St Louis Mo (NO. 3924A St. Louis Av St.; W Ward)

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

2 FULL NAME Anna M. Landzettel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: August (Month) 27 (Day), 1856 (Year)

7 AGE: 62 yrs. 1 mos. 9 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): At Home

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

PARENTS

10 NAME OF FATHER: Peter Mohrmann

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

12 MAIDEN NAME OF MOTHER: Caroline Nierwoehrer

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Hendricks

(Address) 3924A St. Louis Av.

15 Filed OCT 8 1918, 191 Mar C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 5 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 20, 1918, to death, Oct. 5, 1918, that I last saw her alive on October 5, 1918, and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis (Capillary)

92A

107B (Duration) 1 yrs. Over mos. six ds.

CONTRIBUTORY (Secondary) Chronic Valvular Disease of Heart (Mitral Regurgitation) (Duration) 3 yrs. — mos. — ds.

(Signed) Edwin Sauter M. D.

Oct. 7th, 1918 (Address) 1331 No. 7th Str.

*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: Calvary Cemetery

DATE OF BURIAL: 1918, 1918

20 UNDERTAKER: Bergesch Und. Co

ADDRESS: 3661 Washington Av

1 PLACE OF DEATH

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

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (No. 3924 A St Louis Av St. ..... Ward)

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

2 FULL NAME Anna M. Landzettel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6 DATE OF BIRTH August (Month) 27 (Day) 1856 (Year)

7 AGE .....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) at home

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

PARENTS

10 NAME OF FATHER Peter Mohrmann

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

12 MAIDEN NAME OF MOTHER Caroline Neuschar

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Hendrick
(Address) 3924 A St Louis Av

15
Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
.....(Month) .....(Day), 191.....(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 PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD