LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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. 36195

or

Village ..... Primary Registration District No. 1003 Registered No. 9565

or

City St Louis (NO. 1544 S 3 St.; 8 Ward)

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

2 FULL NAME Mary Majket Majher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widow

6 DATE OF BIRTH about (Month) (Day) 1858 (Year)

7 AGE about 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER Michall Minar

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) Sofie Faltin
(Address) 1544 S 3 St.

15 Filed [illegible] 191 Mary C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 12 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 8, 1918, to Oct 12, 1918, that I last saw her alive on Oct 12, 1918, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

97 Asthma 96
112

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

CONTRIBUTORY (Secondary) Interco-sclerosis

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

(Signed) E C Loew M. D.

10-14, 1918 (Address) 1413 S. Bway

*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 SS Peter & Paul

DATE OF BURIAL Oct 14, 1918

20 UNDERTAKER Wm. C. Moydell

ADDRESS 1926 Allen av

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 St Louis (NO 5441 Dresden St.; ..... Ward)

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

2 FULL NAME Antonia Schiller

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH ..... (Month) ..... (Day), 1..... (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 Oct. (Month) 5 (Day), 1918 (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 5 40 p. 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**