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. 49097

or

Village ..... Primary Registration District No. 1003 Registered No. 13071

or

City St. Louis (NO. 4509 N. 19 St. St.; 1 Ward)

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

2 FULL NAME Nellie Oppermann

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 Oct. 15th 1885 (Month) (Day) (Year)

7 AGE 33 yrs. 1 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER John Boylan

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

12 MAIDEN NAME OF MOTHER Mary Grimes

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph C. Oppermann

(Address) 4509 N 19 St.

15 Filed DEC 9 1918 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 7 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 1 1918, to Dec 7 1918 that I last saw her alive on Dec 7 1918 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108

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

CONTRIBUTORY (Secondary) .....

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

(Signed) H W Beurg M. D.

Dec 8 1918 (Address) 802 Salisbury

*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 Cemetary

DATE OF BURIAL Dec 9th 1918

20 UNDERTAKER G Bockers L & Co.

ADDRESS 4320 Warner

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

MISSOURI STATE BOARD OF HEALT
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 occurre hospital or insti give its NAME i of street and nur

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

..... (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

....., 191..
(Month) (Day)

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 19

that I last saw h.....alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed).....M

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal or Homic

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

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