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

Do not use this space.

2639

1. PLACE OF DEATH

County ..... Registration District No. ..... 75 ..... File No. 200

Township ..... Primary Registration District No. ..... 1003 ..... Registered No. 2

City St Louis Mo. (No. 2606 Madison St. ..... St. ..... Ward)

2. FULL NAME Mary Louise Heim

(a) Residence. No. 2606 Madison St., 20 Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 9 - 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	67	10	26	

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

9. BIRTHPLACE (CITY OR TOWN) St Louis Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Conrad Lang.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany.

12. MAIDEN NAME OF MOTHER Dont know.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany.

14. INFORMANT Daniel F. Lang.
(Address) 2606 Madison St.

15. FILED JAN -6, 1927 Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1927

17. I HEREBY CERTIFY, That I attended deceased from 12-1-26 Dec 1st, 1926, to Jan 5th, 1927 that I last saw her alive on Dec 30th, 1926, and that death occurred, on the date stated above, at 9 - A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy - Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
(duration) 3 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical diagnostic
(Signed) Robert L. Foster, M.D.
, 19 (Address) 1505 N. Jefferson St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Peter — DATE OF BURIAL Jan 8 1927

20. UNDERTAKER Hy Leidner Und Co — ADDRESS 1417 N. Market St

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.