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

Do not use this space.

3432

File No. 1067

Registered No.

1. PLACE OF DEATH

County

Registration District No. 791

Township

Primary Registration District No. 1003

City St. Louis Mo. (No. 1450 N. Market St St. Ward)

2. FULL NAME Agnes Leybold

(a) Residence. No. 1450 N. Market St St., 26 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

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) July 24 - 1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	71	6	5	

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) Germany.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Dont know.

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

12. MAIDEN NAME OF MOTHER Dont know.

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

14. INFORMANT Mrs. Rose Winkler
(Address) 1450 N. Market St.

15. FILED JAN 31 1927 May C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 1927.

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1927, to Jan 29, 1927 that I last saw h. alive on 1/29, 1927, and that death occurred, on the date stated above, at 6 h. p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1/ Myocarditis - Chr.
2/ Senile
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Nephritis Chr. Interstitial
(duration) 3 yrs. 8 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 & Lab.

(Signed) F. D. Leake M. D.

1/29, 1927 (Address) 2303 N 15th 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 Bethany

DATE OF BURIAL Feb. 1 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD