

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

Do not use this space.

0029

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. Home for the aged)

File No.....
 Registered No. **1179**
 St. (Ward)

2. FULL NAME

Annie Schlack

(a) Residence, No. 3400 S. Grand Blvd. 16 Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt. 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 72

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) (STATE OR COUNTRY) Bohemia

10. NAME OF FATHER Joseph Schlack

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

12. MAIDEN NAME OF MOTHER Francis Leiser

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

14. INFORMANT Sister Michael
 (Address) 3400 S. Grand Blvd.

15. FILED Feb -2 1927 Mar. C. Starceoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 25 1927 to Feb 11 1927, 1927, that I last saw her alive on Feb 11 1927, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
99 Cerebral hemorrhage
apoplexy
 (duration) yrs. mos. da. 6

CONTRIBUTORY (SECONDARY) arteriosclerosis
 (duration) yrs. mos. da. 6

18. WHERE WAS DISEASE CONTRACTED? 7400
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? Dr. Sauer
 (Signed) M.D.
 (Address) 3141 E. 2nd

*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 & Paul Cemetery **DATE OF BURIAL** Feb. 3 1927

20. UNDERTAKER J. H. Gebkin & Co. **ADDRESS** 2842 Myramore

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.

