

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

Do not use this space.

60.14

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.*

(No. *City Hospital*)

File No.

Registered No. **1267**

St. Ward)

2. FULL NAME *Magdalena Pfiffner*

(a) Residence, No. *1924 Provencher Pl.* St., *23* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 15-1874*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

52

6

18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House Wife

(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)

Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT (Address)

*Joseph Pfiffner
1924 Provencher Pl.*

15.

FILED

FEB - 5 1927 Maul & Starkeoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb. 3 - 1927*

17.

I HEREBY CERTIFY, That I attended deceased *John P. [unclear]*

....., 19*27*, to *Feb 3*, 19*27*, that I last saw him alive on *Jan 31*, 19*27*, and that death occurred, on the date stated above, at *St. Louis Mo.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Arterio Sclerosis Chronic Ill
131 Memphis Avenue
99*

137E (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

137E (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH: *at Hospital*

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *Physical Ex.*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical Ex.*

(Signed) *John P. [unclear]*, M. D.

3, 19*27* (Address) *314 1/2 4930 [unclear]*

*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

DATE OF BURIAL

S. S. Peter & Paul [unclear]

Feb. 6 - 1927

20. UNDERTAKER

ADDRESS

Ziegenhain Bros. 2643 Cherokee

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.

