

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

Do not use this space.

6368

1. PLACE OF DEATH

County.....

Registration District No. **791**

Towaship.....

Primary Registration District No. **1093**

City.....

City No. 52715 Kansas Ave

File No.....

Registered No. **1560**

St.

Ward)

2. FULL NAME

(a) Residence. No. **52715 Kansas St.** St. **2** 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

4. COLOR OR RACE

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

Female White

Single

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

Widow

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

Oct 26th 1869

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day,hrs. ormin.

57

3

18

8. OCCUPATION OF DECEASED

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

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Same at home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St Louis Mo

10. NAME OF FATHER

Ferdinand E. Mittenberger

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St Louis Mo

12. MAIDEN NAME OF MOTHER

Marie Stofell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Prague

14. INFORMANT

(Address)

Le R. Mittenberger 3704 North 4th St

15. FILED

FEB 15 1927

Max C. Starkeoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Feb 15 1927

17.

I HEREBY CERTIFY, That I attended deceased from
Jan 29....., 19*27*, to *Feb 14*....., 19*27*
that I last saw him alive on *Feb 14*....., 19*27*, and that
death occurred, on the date stated above, at *3:45 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

10 Lobes Pneumonia

90 F 95 F 101 A

CONTRIBUTORY *Irregular heart* -
(SECONDARY) *Chronic Pericarditis*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)..... *A. P. Fabig*....., M. D.

, 19 (Address) *5817 Leavitt*

*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

Cabary Cemetery Feb 16 1927

20. UNDERTAKER

ADDRESS

Fauke & Schmitt S. Grand

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.

