

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

Do not use this space.

6375

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City..... (No. *Jewish Hospital*)

File No.....
 Registered No. **1567**
 St. Ward)

2. FULL NAME *Mary Weiner*

(a) Residence No. *4032 W 23* St. *26* Ward.
 (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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Walter Weiner</i>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>12-2-1888</i>				
7. AGE	YEARS <i>38</i>	MONTHS <i>2</i>	DAY <i>11</i>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <i>Housewife</i>				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) *St Louis County*
 (STATE OR COUNTRY) *MO*

10. NAME OF FATHER *John Cass*

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

12. MAIDEN NAME OF MOTHER *Mary Walters*

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

14. INFORMANT *Walter Weiner*
 (Address) *4032 W 23 Str.*

15. FILED **FEB 15 1927** *Maul & Starbuck*
 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb. 13 1927*

17. I HEREBY CERTIFY, That I attended deceased from *8th Feb* 19*27* to *13th Feb* 19*27* that I last saw her alive on *13th Feb* 19*27*, and that death occurred, on the date stated above, at *11:15 A. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
1/85
30

CONTRIBUTORY (SECONDARY) *Infectious Anem. accidentally*
Infectious mouth cutting her fingers

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? *but know*

19. DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *9th Feb.*

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Blood Exam -*
 (Signed) *Vincent Lock*, M. D.
2/14 1927 (Address) Humbolt Bldg

*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 *Calvary Cemetery* DATE OF BURIAL *2/16 1927*

20. UNDERTAKER *H. A. Stock and Co* ADDRESS *2117 E. 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.

