

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

Do not use this space.

9732

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

City Hospital

File No.....

Registered No.....

2671

St.....

Ward.....

2. FULL NAME

(a) Residence. No. *2756* *Bacon St.* Ward. *11*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *56* yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

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

Widowed

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

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

April 18 - 1870

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, tra. or min.
<i>56</i>	<i>5</i>	<i>18</i>	

8. OCCUPATION OF DECEASED

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

Stewardess

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Mariis

(STATE OR COUNTRY)

10. NAME OF FATHER

Julius Snider

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Regina Jannica

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

City Hospital

15.

FILED

19

Mar 6 Starckoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 6 1927*

17. I HEREBY CERTIFY That I attended deceased from *Jan 19 1927* to *March 6 1927*

that I last saw her alive on *March 27*, and that death occurred, on the date stated above, at *4:50 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebrospinal Syphilis
Chr. Bronchitis from Tuberculae
17 years (duration)
 CONTRIBUTORY (SECONDARY) *Pneumonia due to*
acute Myocarditis

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) *R. M. Smith*

M. D.

*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

Frederick

Mar 9 1927

20. UNDERTAKER

ADDRESS

Hy Leidner Und Co St. Market

N. E.—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.

MISSOURI STATE BOARD OF HEALTH

PERMANENT RECORD

Grandson