

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

Do not use this space. 9758

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township **St. Louis**

Primary Registration District No. **1003**

City **St. Louis**

(No. of **St. Marys Infirmary 1536 Papin** St. **2512** Ward)

2. FULL NAME

(a) Residence. No. **Margaret Epstein 4018 Laeblade St. 18** Ward.

(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 2-1864**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 6 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **at Home**

(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 **John Becker**

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) **Mrs Clara Felth 4018 Laeblade**

15. FILED **1927** **Margaret Epstein** REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3/5/27** 19

17. I HEREBY CERTIFY, That I attended deceased from **2-25-27**, 19, to **3/5/27**, 19, that I last saw him alive on **3/5/27**, 19, and that death occurred, on the date stated above, at **8:10 p.m.**

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chromi myraditis
1290 (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Chromi myraditis** (duration) ? yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH. **No.** DATE OF

WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS.

(Signed) **Eugene H. Mout**, M. D. **3/6/27** (Address) **1536 Papin**

*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 **3/9 1927**

20. UNDERTAKER **Arthur J. Dornelly** ADDRESS **2039 Wash St**

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.

THIS IS A PERMANENT RECORD

