

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

Do not use this space.

9866

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City St. Louis Mo. (No. ....) Sanitarium St. .... Ward)

File No.....  
 Registered No. 2535

**2. FULL NAME**

Barbara Paechal

(a) Residence. No. 223 Kellie St., 13 Ward. St. Louis Mo.  
 (Usual place of abode) (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) widowed

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
about 64

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housework  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... Unknown  
 (STATE OR COUNTRY) Bohemia

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT Joseph Kohler  
 (Address) 5300 Arsenal

15. FILED May 6 1927  
 19.....

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/8/27 19.....

17. I HEREBY CERTIFY, That I attended deceased from 2/27/27, 19....., to 3/8/27, 19....., that I last saw him alive on 3/7/27, 19....., and that death occurred, on the date stated above, at..... 90 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral hemorrhage, apoplexy  
1917  
 (duration)..... yrs. .... mos. 1 ds.

CONTRIBUTORY Arterio-sclerosis  
 (SECONDARY) (duration)..... yrs. .... mos. 13 ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
3/8/27 (Signed) Joseph Kohler M. D.  
 , 19 (Address) 5300 Arsenal

\*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

Missouri Cremery 3/12 1927

20. UNDERTAKER ADDRESS 7315

South 1300

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.

PERMANENT RECORD

