

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

Do not use this space.

9967

1. PLACE OF DEATH

County.....
Township.....
City.....
Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **2542**
St. Ward

2. FULL NAME

(a) Residence. No. **3510 Cass St.** Ward. **21**
(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 (specify the word) **Widowed**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 2 1859**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **67 6 10**
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)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
10. NAME OF FATHER **Shoat**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
12. MAIDEN NAME OF MOTHER **Not known**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT (Address) **Anthony Lechleiter 3510 Cass Ave**
15. FILED **7-1-1927** **May G. Starceoff** Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 12 1927**
17. I HEREBY CERTIFY, That I attended deceased from **June 19 1927** to **March 12 1927**, that I last saw him alive on **March 11 1927**, and that death occurred, on the date stated above, at **4:30 P.M.**
18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
11/29 W
CONTRIBUTORY **Arterio Sclerosis** (SECONDARY) (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....
WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **J. P. Thompson, M.D.**
3/12, 1927 (Address) 3108 Leiss

*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 **St. Peter & Paul Church, Nov 15 1927**
20. UNDERTAKER ADDRESS **J. J. Quinn 1032 N. Grand**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

4

