

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

Do not use this space.

16928

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... (No. *Seaconess Hoft*)

Registration District No. **791**  
Primary Registration District No. **1003**

File No.....  
Registered No. **4881**  
St. .... Ward)

**2. FULL NAME** *Barbara Spielmann*

(a) Residence. No. *Seaconess Hoft 11* Ward. (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**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 *John Spielmann*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5-8-1845*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *82 0 15*

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) *Germany*  
(STATE OR COUNTRY)

10. NAME OF FATHER *Unknown Neuenrather*

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

12. MAIDEN NAME OF MOTHER *Neuenrather*

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

14. INFORMANT *John Sluyser*  
(Address) *3619 Palm St.*

15. FILED *24 24 1927* *May 6 Starkeroff*  
19... Registrar

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 23 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Apr 27*, 19*25*, to *May 23*, 19*27*, that I last saw her alive on *May 23*, 19*27*, and that death occurred, on the date stated above, at *6:10 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*131 Central Hemorrhage (apoplexy)*  
*82A*  
(duration) yrs. mos. *4* ds.

CONTRIBUTORY (SECONDARY) *Chronic Interstitial Nephritis*  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? *1290*  
IF NOT AT PLACE OF DEATH?

Did AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Urinalysis Physical Examination*

(Signed) *A. R. Pfeiffer*, M. D.

*May 24, 1927* (Address) *1021 Missouri Bldg. W. Lau*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

*Sunset Burial* *May 25 1927*

20. UNDERTAKER ADDRESS *Provost Und Co 3710 N. 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.

WHICH IS A PERMANENT RECORD

Dr H. R. Sherrill  
15th St. & 2nd Ave. Traction Bridge  
9 7/10 A.M.  
2 - 3 P.M.