

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

Do not use this space.

17023

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

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

File No.....  
Registered No. **4986**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *5535 Thrush Ave.* St. *7* 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Female* | *white* | *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 13, 1854*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
*72* | *6* | *13*

**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 *Not known*

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) *Benjamin C. Marks 5535 Thrush Ave*

15. FILED *20 1927* *may 20 1927* *max C. Starkeoff* REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 26 1927*

17. I HEREBY CERTIFY, That I attended deceased from *May 1st 1927* to *May 26 1927*, that I last saw her alive on *May 26 1927*, and that death occurred, on the date stated above, at *5535 Thrush Ave.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Interstitial nephritis*  
*chronic*  
*131*  
*130* (duration) *1290* yrs. mos. *30* ds.  
CONTRIBUTORY *acute nephritis* (SECONDARY) (duration) yrs. mos. *45* 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? *Usual Sym. Tests*  
(Signed) *P. E. Aldenderfer* M. D.  
(Address) *3555 Robin Av.*

\*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 *Friedens* DATE OF BURIAL *May 28 1927*

20. UNDERTAKER *Math. Hermann & Co.* ADDRESS *4132 Wood*

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.

