

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis Registration District No. 784 File No. 19341
 Township St. Bernard Primary Registration District No. 6030 Registered No. _____
 City Jennings Mo (No. 5560, Jennings Rd) St. _____ Ward)

2. FULL NAME

Johanna A. Stein
 (a) Residence No. _____ St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 1st 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 2 25

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) East St. Louis Ills
 (STATE OR COUNTRY)

10. NAME OF FATHER John H. Meyer

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT John S Stein
 (Address) 5560 Jennings Mo

15. FILED June 28th 1927 O. V. Schmidt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) June 26 19 27

17. I HEREBY CERTIFY That I attended deceased from 7:25 1927 to 10:30 P 1927, and that I last saw him alive on 6-26, 1927, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Intestinal
31 nephritis
924
1290
 CONTRIBUTOR (SECONDARY) Valvular Heart Disease
 (duration) 2 yrs. mos. da.
 (duration) 1 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. M. Owens, M. D.

6/27 1927 (Address) 2032 Mc Laren Ave

*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

Calvary June 29 1927

20. UNDERTAKER ADDRESS

Math Hermann & Son 4103 Duverant Ave

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.

