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

Do not use this space.

22928

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 6604

City St Louis (No. Mo Baptist Sanitarium St. ..... Ward)

2. FULL NAME Helen Kammerer

(a) Residence. No. 919 N. Taylor St., 12 Ward. Louisiana 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mr Albert Kammerer

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 29 1897

7. AGE: Years 30 Months 5 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: 36
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Bury Mo.

PARENTS
10. NAME OF FATHER: Henry Langerhans
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Jefferson City Mo.
12. MAIDEN NAME OF MOTHER: Martha Rane
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Bury Ill

14. INFORMANT: Theo C Braun
(Address): St Louis Mo.

15. FILED 11 20 1927 Max C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-19- 1927

17. I HEREBY CERTIFY, That I attended deceased from 3-18-, 1927, to 7-19-, 1927 that I last saw her alive on 7-19-, 1927 and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Streptococcus pyoemia and septicaemia (Streptococcus Hemolyticus) (duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY): Operation for Exophthalmic Goitre (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Yes DATE OF March 18th 27
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) R K Andrews, M. D
, 19 (Address) 503 Wall Bldg

*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: Louisiana, Mo. DATE OF BURIAL: 7/22 1927

20. UNDERTAKER: Haley Und Co ADDRESS: Louisiana Mo

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.

Ms. Baptist

4/30

MAY 24 1955