

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

Do not use this space.

25449

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis Mo.* (No. *Beacon Hill Hospital*)..... St. Ward)

File No.....
 Registered No. **6982**
 St. Ward)

2. FULL NAME *Pauline Hoerner*
 (a) Residence. No. *3540 Illinois Ave.* St. *24* 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. 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** *Married*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug. 28-1877*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 *11* *3*

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 *Charles Hoerner*
 (Address) *3540 Illinois Ave.*

15. FILED *1927* *May 6 Starceff*
 (Date) (Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 10* 19 *27*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 25* 19 *27* **to** *Aug 25* 19 *27*
 that I last saw him alive on *Aug 25* 19 *27*, and that death occurred, on the date stated above, at *11:30 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Meningitis
Streptococcus
enteritidis
 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *old chum abscess*
medic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, *Beacon Hill*

DIDIAN OPERATION PRECEDE DEATH? *Yes* DATE *7-6*

WHAT TEST CONFIRMED DIAGNOSIS? *General Exam*
 (Signed) *J. J. Sheet* M. D.
8/1, 19 *27* (Address) *4930 Ruler*

*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 *S. S. Peter + Paul* **DATE OF BURIAL** *Aug. 3* 19 *27*

20. UNDERTAKER *Ziegenhein Bros. 2623 Cherokee*
 ADDRESS

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.

Dr. J. J. Sheet

