

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

Do not use this space.

25658

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City, *St. Louis Mo* (No. *Seasoness Hosp*)..... St. *7255* Ward)

**2. FULL NAME** *Dorothy Edna Kreichelt*  
 (a) Residence, No. *1427 Locust St.* St. *24* 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** *Female* | **4. COLOR OR RACE** *White* | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Married*  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** *July 2<sup>d</sup> 1891*  
**7. AGE** Years: *31* | Months: *1* | Days: *8* | If LESS than 1 day, hrs. or min.  
**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)** *Paris France* (STATE OR COUNTRY)  
**10. NAME OF FATHER** *Davidson Bunnell*  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** *France* (STATE OR COUNTRY)  
**12. MAIDEN NAME OF MOTHER** *Don't know*  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** *France* (STATE OR COUNTRY)

**14. INFORMANT** *Chas Buschart* (Address) *1427 Locust St.*

**15. AUG 11 1927** FILED *Mac C. Starck* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *Aug 10 1927*  
**17. I HEREBY CERTIFY**, That I attended deceased from *Aug 10 1927* to *Aug 10 1927*, that I last saw h. *alive on Aug 10 1927*, and that death occurred, on the date stated above, at *3:30 P. M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Hydatid Disease of Liver - Malignant*  
 (duration) *2* yrs. *2* mos. *2* ds.  
**CONTRIBUTORY** *Dysentery (Cholera)* (SECONDARY)  
 (duration) *2* yrs. *2* mos. *2* ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH.....  
**19. DID AN OPERATION PRECEDE DEATH?** *No* DATE OF *Aug 5 1927*  
**20. WAS THERE AN AUTOPSY?** *No*  
**WHAT TEST CONFIRMED DIAGNOSIS?** *Microscopic*  
 (Signed) *[Signature]* M. D.  
*8/11 1927* (Address) *3833 Wash St*

\*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** *Valhalla* DATE OF BURIAL *Aug 13 1927*

**20. UNDERTAKER** *Wm. Leidner and Co. 1417 Market St*

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No.....  
Township..... Primary Registration District No. 1003 Registered No. 7255  
City St. Louis (No. .... St. .... Ward)

**2. FULL NAME**

Dorothy Edna Kreichelt  
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 2 - 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
36 1 8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
(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).....

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT (Address).....

15. FILED NOV -9 1927 Mar C. Starkeoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 1927

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

..... (duration)..... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATHY..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.  
, 19 (Address)

\*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

20. UNDERTAKER ADDRESS

REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

S-25658