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

Do not use this space.

25955

1. PLACE OF DEATH

County ..... Registration District No. 781 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 7573

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

2. FULL NAME Victoria Dober

(a) Residence. No. 1219 N. 11th St., 13 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 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 Jacob Dober

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25, 1878.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	48	7	26	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Austria

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Louis H. Kohler
(Address) 5300 Arsenal

15. FILED AUG 24 1927 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/21/27 19

17. I HEREBY CERTIFY, That I attended deceased from 7/21/25, 19..., to 8/20/27, 19..., that I last saw her alive on 8/20/27, 19..., and that death occurred, on the date stated above, at 5 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Syphilis of the Central Nervous System
38
(duration) 13 yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) 38
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) Louis H. Kohler M. D

8/21/27, 19 (Address) 5300 Arsenal

*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 Washington, Ill. DATE OF BURIAL 8/24/27

20. UNDERTAKER W Richter ADDRESS 3500 Rutgers

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.