

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

Do not use this space.

128227

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City St. Louis

Registration District No. 785
Registration District No. 6248
Name Hillworth Hospital

File No. _____
Registered No. 179
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 660 E. Monroe Kirkwood Mo. 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 (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED (husband or wife) Wife of Peter Lischer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 6-1884

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 43 0 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife
(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) Missouri

10. NAME OF FATHER

Lorenz H. Koenig

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Elisa Rodel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Switzerland

14.

INFORMANT Peter Lischer
(Address) 660 E. Monroe Kirkwood Mo.

15.

FILED 10/10/27 C. E. Barnett, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7th 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 29th, 1927, to Sept 7th 1927 that I last saw her alive on Sept 30th, 1927, and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis
Salphage (Bilateral)
(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 DEATH. yes DATE OF Sept 7th 1927

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. Alford Smith, M.D.
Sept 7, 1927 (Address) W. Alford Smith

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Mascoutah Ill DATE OF BURIAL Sept. 9 1927

20. UNDERTAKER

Louis H. Bopp, Kirkwood Mo. ADDRESS Kirkwood Mo.

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.

OCT 23 1927

**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 St. Louis
Township Carondelet
City (No.) St. Ward

Registration District No. 483
Primary Registration District No. 6248

File No.
Registered No. 173
St. Ward

2. FULL NAME

Diana H. Lescher
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

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 10/10 1927 C. Barnett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7 19 27

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Peritonitis & Salpingitis (By lateral)

CONTRIBUTORY (SECONDARY) Also uterine prolapse

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 138

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

RECORD
PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
of information should be carefully classified. Exact statement of OCCUPATION is very important.
CAUSE If in plain terms, so that it may be RE-TRANS

5-28227