

OCT 2 1927

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

Do not use this space.

28293

1. PLACE OF DEATH

County *St. Louis*
Township *Waldenville*
City *Carrville*

Registration District No. *1123*
Primary Registration District No. *62486*
(No. *4944-Deege Road*)

File No.
Registered No. *343*
St. Ward)

2. FULL NAME

Katherine Anne Schall
(a) Residence. No. *4944-Deege Road 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

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

Charles J. Schall

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

Mar 20-1868

7. AGE

59

YEARS

5

MONTHS

27

DAYS

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) (STATE OR COUNTRY)

St. Louis Mo

10. NAME OF FATHER

Hy Mckdenberg

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

Germany

12. MAIDEN NAME OF MOTHER

Mary Schwartz

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

Germany

14.

INFORMANT

(Address)

*Charles J. Schall
4944-Deege Road*

15.

FILED

*19 27**L. C. Obrock**REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 17 1927*

17.

I HEREBY CERTIFY, That I attended deceased from *Apr 25*, 19*27*, to *Sept 17*, 19*27* that I last saw *her* alive on *Sept 17*, 19*27*, and that death occurred, on the date stated above, at *10:5A*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

carcinoma of ascending colon

CONTRIBUTORY (SECONDARY)

45 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *Apr 27/24*WAS THERE AN AUTOPSY? *no*WHAT TEST CONFIRMED DIAGNOSIS? *Op. & clinical*(Signed) *Walter M Jones*, M. D.*10-18-1927 (Address) 3400 Meramec*

*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

*St Peter Paul**Sept 20 1927*

20. UNDERTAKER

ADDRESS

*Wacker-Heldorfe**2331 S Bldg*

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.

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