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

Do not use this space.

31877

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9239

City ..... (No. 4791 Sacramento St. ..... Ward)

2. FULL NAME Jeanette Hummel

(a) Residence. No. 4701 Sacramento St., 7 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): —

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8 - 1927

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	1	9	

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) St. Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Fred Hummel
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Lillian Hunkinger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo

14. INFORMANT Fred Hummel
(Address) 4701 Sacramento ave

15. FILED OCT 17 1927 19.. Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 - 1927, to Oct 17 - 1927 that I last saw her alive on Oct 17 - 1927, and that death occurred, on the date stated above, at 5 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Spinal meningitis
159B
79A
..... (duration) ..... yrs. ..... mos. 3 ds.

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

18. WHERE WAS DISEASE CONTRACTED? 1 Sept
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) T. Kleyer, M. D
10-17-1927 (Address) University Club Bldg.

*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: St. Johns Cemetary North
DATE OF BURIAL: Oct 19 1927

20. UNDERTAKER: Stroot-Carroll
ADDRESS: 4600 Max 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.