

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

Do not use this space 460

34652

Should state CAUSE OF DEATH properly and in full. Very important.

1. PLACE OF DEATH

County St. Louis Registration District No. 1123
 Township Carondelet Primary Registration District No. 6248 C
 City St. Louis (No.) St. Ward (....)

2. FULL NAME

Catherine Huelwing
 (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 <u>of</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>S</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 11 1927</u>		
7. AGE	YEARS	MONTHS
<u>X</u>	<u>6</u>	<u>4</u>
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 County, Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Bernard Huelwing

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

12. MAIDEN NAME OF MOTHER Agnes Brune

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

14. INFORMANT Ben Huelwing
 (Address) St. Louis County

15. FILED Nov. 15 1927 L. C. Obrock
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 15 1927
 17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1927 to Nov. 15 1927
 that I last saw her alive on Nov. 15 1927, and that death occurred, on the date stated above, at 4:50 a. m.

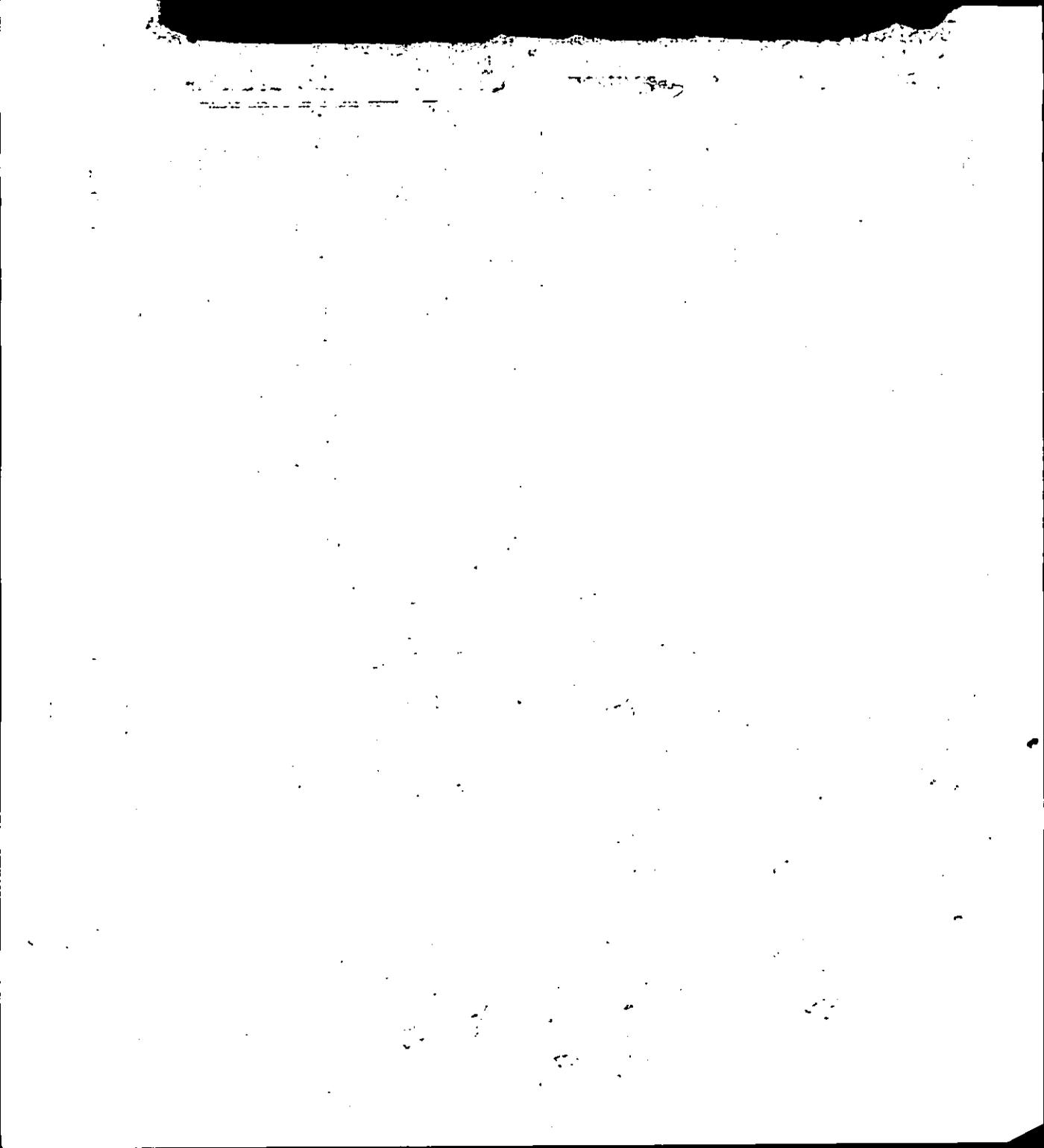
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-Pneumonia
about 7 (duration) yrs. mos. ds.
 CONTRIBUTORY none
 (SECONDARY)
Had been under treatment of a (duration) yrs. mos. ds.
St. Louis (Mo.)

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, ...
 DID AN OPERATION PRECEDE DEATH? ... DATE OF ...
 WAS THERE AN AUTOPSY? ...
 WHAT TEST CONFIRMED DIAGNOSIS?
L. C. Obrock (Signature) M. D.
 , 19 (Address) 779 LeMay Rd.

*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. Olive's Cem. DATE OF BURIAL Nov 17 1927

20. UNDERTAKER Heardley M. Co. ADDRESS 7819 M. Ch.



**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 Registration District No. 1123 File No.
Township Carondelet Primary Registration District No. 6248c Registered No. 400
City (No.) St. Ward

2. FULL NAME

(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 (write the word) S

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 FEB 22 1928 L. C. Obrock M. U. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 13 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, m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
Primary acute
case bronchopneumonia
none (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? 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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full, and, to that it may be properly classified. OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNDER THIS ACT.

SUPPLEMENTARY

259455