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

Do not use this space.

35189

File No.
Registered No. 10365

1. PLACE OF DEATH

County
Township
City St. Louis (No. Isolation Hosp. St. Ward)

Registration District No. 791
Primary Registration District No. 1003

2. FULL NAME Lindell Stechmesser

(a) Residence. No. 6443 Nashville St., 4 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-31-1926

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	1	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(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)

PARENTS
10. NAME OF FATHER Ernest Stechmesser
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Marie Meyer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

14. INFORMANT Marie Stechmesser (Mother)
(Address) 6443 Nashville

15. FILED NOV 19 1927 Max C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov-16, 1927, to Nov-17, 1927 that I last saw h. alive on Nov-17, 1927, and that death occurred, on the date stated above, at 11:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
Primary
101A (duration) — yrs. — mos. 5 ds.
CONTRIBUTORY (SECONDARY) 1000 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 6443 Nashville
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Joseph H. Garrison, M. D
, 19 (Address) Isolation Hospital

*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 Warrenton Mo.
DATE OF BURIAL 11-20 1927

20. UNDERTAKER Geo. L. Pleitsch
ADDRESS 5966 Easton

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD