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

Do not use this space.

38428

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 11096

City St Louis (No. City Hospital St. ..... Ward)

2. FULL NAME Beatrice Chabdaratz

(a) Residence. No. 716 Marion St., 23 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? 15 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 OF (OR) WIFE OF: Milan Chabdaratz

6. DATE OF BIRTH (MONTH, DAY AND YEAR): about 1985

7. AGE: about 22 YEARS; MONTHS —; DAYS —; If LESS than 1 day, ... hrs. or ..... min.

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): Servia

PARENTS

10. NAME OF FATHER: George Novakovich
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Servia
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Milan Chabdaratz
(Address): 716 Marion St

15. FILED DEC 12 1927 19 Max C Stanzoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 10 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1927, to Dec 10th, 1927 that I last saw her alive on Dec 9th, 1927, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis

[illegible] 146 (duration) 56 yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY): Eclampsia (Puerperal following childbirth) (duration) — yrs. — mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at place of death

0 DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) W A Fries, M. D

12/12, 1927 (Address) 1544 So. Broadway

*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: Mt Hope Cemetery — DATE OF BURIAL: Dec 13 1927

20. UNDERTAKER: Wm C. Mondell — ADDRESS: 1926 Allen

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.

[illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD