

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

Do not use this space.
38812-a

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... (No. **4353^a Peurto**)

File No. **11545**
Registered No. **11545**
St. Ward)

2. FULL NAME

Ida Franz
(a) Residence. No. **4353^a Peurto** St. **10** Ward.

(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 Joseph Franz

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-28-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
50 | 4 | 25

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) St Louis
(STATE OR COUNTRY) MO

10. NAME OF FATHER John Ackerman

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Joseph Franz
(Address) 4353^a Peurto St

15. FILED 25 1927
19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1927

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to Dec 23, 1927, and that I last saw her alive on Dec 23, 1927, and that death occurred, on the date stated above, at ____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of breast

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **M. J. Oress**, M. D.

Dec 24, 1927 (Address) 644 Mo 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 Calvary Cem. **DATE OF BURIAL** 12/26 1927

20. UNDERTAKER H. A. Stork M.D. **ADDRESS** 2117 E. 6th

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.

