

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

Do not use this space. **2630**

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **4638**) **St. Louis Ave.** St. **1** (Ward)

2. FULL NAME

(a) Residence. No. **4638** **St. Louis Ave.** St. **1** Ward. (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) **Widow**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 9, 1861**
 7. AGE YEARS MONTHS DAY If LESS than 1 day, ____ hrs. or ____ min.
66 | 8 | 09

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **At Home**
 (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)

10. NAME OF FATHER **James Wiseman**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
 12. MAIDEN NAME OF MOTHER **Hot Brown**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT **Mr. Louis Koepf**
 (Address) **4638 St. Louis Ave**

15. FILED **1918** **Mark Starkeoff**
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 5, 1928**
 17. I HEREBY CERTIFY, That I attended deceased from **34** Sept. 1927, to **Jan 4**, 1928, and that I last saw him alive on **Jan 4**, 1928, and that death occurred, on the date stated above, at **3:30 A. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
43C
178C
 (duration) yrs. **5** mos. ds.
 CONTRIBUTORY **Chronic Catarrhal Gastritis**
 (SECONDARY) (duration) **10** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) **F. C. Barber**, M. D.
 , 19 (Address) **6312 Washington**

*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 **Valhalla** DATE OF BURIAL **Jan. 7, 1928**

20. UNDERTAKER **Math Hermann and Son** ADDRESS **410 3rd St St. Louis Mo**

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.

