

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

Do not use this space.

2895

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

File No. ....

Township.....

Primary Registration District No. **1003**

Registered No. **F 480**

City **St. Louis, Mo.**

**2246 Dodier St.**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **2246** **Dodier St.**, **20** 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

*Female*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Married*

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

*William H. Seifert*

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

*May 12<sup>th</sup> 1870*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

*57*

*8*

*10*

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)

(STATE OR COUNTRY)

*Chester, Ill.*

10. NAME OF FATHER

*Jacob Glass*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Germany*

12. MAIDEN NAME OF MOTHER

*Not known*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Germany*

14. INFORMANT

(Address)

*William H. Seifert  
2246 Dodier St.*

15. FILED

NO. *141*

DATE *7-1-1928*

*Man L. Starkeoff*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**3**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-12* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *12* *noon* *12*, 19 *28* to *12* *noon*, 19 *28* that I last saw h. *er* alive on *July 12<sup>th</sup>*, 19 *28*, and that death occurred, on the date stated above, at *7* *15* *m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Uremia  
434 acute Stenosis*

*113*  
*130* (duration) yrs. mos. ds.

CONTRIBUTORY *Auto nephritis (Chronic)*  
(SECONDARY) (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH DATE OF

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Septic*  
(Signed) *Arthur Tomales*, M. D.

*1/13*, 19 *28* (Address) *2202 Broadway, ST*

\*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

*Chester, Ill.* DATE OF BURIAL *1-14* 19 *28*

20. UNDERTAKER

*Hy. Leidner Und. Co. 1417 N. Market*

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.

arth. gundlach