

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

Do not use this space.

3153

1. PLACE OF DEATH

County.....
Township.....
City..... St. Louis Mo.

Registration District No. 791
Primary Registration District No. 1003
No. Christian Hospital

File No.....
Registered No. 772
St. Ward)

2. FULL NAME Katherine Koetter.

(a) Residence. No. 4332 N. 19th. St. 9 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | White | Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8/30/1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
53 4 19

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) St. Louis Mo

10. NAME OF FATHER Herrvi Breckenkamp.

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

12. MAIDEN NAME OF MOTHER Minnie Kanmeier

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

14. INFORMANT Mrs Koetter (Address) 4332 N. 19th St.

15. FILED Mar 6 Starceoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/19/28 19

17. I HEREBY CERTIFY That I attended deceased from Jan 19 1928 to Jan 19 1928 that I last saw h. alive on Jan 19 1928, and that death occurred, on the date stated above, at I P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Apoplexy cerebral
hemorrhage

CONTRIBUTORY (SECONDARY) Apoplexy (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 74 Wt
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Wm. Ross M. D. , 19 (Address) 1918 S. Grand

*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 Trideus. DATE OF BURIAL 1-22-1928

20. UNDERTAKER Provost Und. Co ADDRESS 7710 N. Grand

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.

