

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

Do not use this space.

6450

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... **St. Louis Mo** Primary Registration District No. **1003** File No.
 City..... (No. **Lutheran Hospital**) Registered No. **1359** Ward)

2. FULL NAME

(a) Residence. No. **6239 Alamo Ave** St. **5** 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female *White* *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *August 12 1868*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 *5* *21*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housework*
 (b) General nature of industry, business, or establishment in which employed (or employer) *At Home*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Unknown Priezel*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Hilda Schlicher*
 (Address) *6239 Alamo Ave*

15. FILED - 6 1023 *Maye Starkoff*
 FILED 19 *1928* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 3 1928*

17. I HEREBY CERTIFY That I attended deceased from *1-30-1928* to *2-3-1928*
 that I last saw her alive on *1-3-1928*, and that death occurred, on the date stated above, at *11 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

appurudicial abuse
 (duration) yrs. mos. ds. *14*

CONTRIBUTORY (SECONDARY) *general peritonitis & lobar pneumonia*
 (duration) yrs. mos. ds. *3*

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

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *Jan 30*
 WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *post mortem*
 (Signed) *Heenan Nauwer*, M. D.

2/4, 1928 (Address) *3651 Delmar*

*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 Cemetery* DATE OF BURIAL *Feb 6 1928*

20. UNDERTAKER *Wm. Robert* ADDRESS *1915 - 5 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.

PERMANENT RECORD

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003
(No. Lutheran Hosp.)

File No.....
Registered No. 1359
St. Ward)

2. FULL NAME

Emma Remmers
(a) Residence. No. 6239 Alamo St., 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22nd 1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>59</u>	<u>5</u>	<u>11</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration)..... yrs. mos. ds.
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Joseph P. Robert
(Address) 1905 S Grand Blvd

15. FILED 23 1094 May 6 Starzoff
19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-3-1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (duration)..... yrs. mos. ds.

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

IMMUTABLE RECORD

