

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

Do not use this space.

10664

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St Louis*

Registration District No..... **791**  
Primary Registration District No..... **1003**  
(No. *2775, O'Leary Ave.*)

File No.....  
Registered No..... **2409**  
St..... Ward.....

**2. FULL NAME**

*Charlotte Bunselmeyer*  
(a) Residence. No..... 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. 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 *St Louis Bunselmeyer*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 6 1848*

7. AGE . . . YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.  
*79 3 24*

**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)**

(STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *Wm O'Leary*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs Minnie O'Leary*  
(Address) *3115 O'Leary Ave.*

15. FILED *APR - 5 1922* *may 6 Starsky*  
19..... REGISTRY

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 2nd* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 10th* 19 *28* to *Mar 2nd* 19 *28*  
that I last saw her... alive on *Mar 2nd* 19 *28*, and that death occurred, on the date stated above, at *8* a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Acute Bronchopneumonia*  
*9 days following La Grippe*  
*167 days* (duration) yrs. mos. *11* ds.

CONTRIBUTORY (SECONDARY) *Chronic* (duration) *5* yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPSY? *No*

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) *H. Klepper*, M. D.

*3/2* 19 *28* (Address) *3808 Broadway*

\*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**

*New Bethlehem*

*Mar 5 1928*

**20. UNDERTAKER**

**ADDRESS**

*Thos H. Bidemann*

*1936 St Louis Ave*

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.

