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

Do not use this space.

File No. 14804

Registered No. 3669

1. PLACE OF DEATH

County ..... Registration District No. 791 1008

Township ..... Primary Registration District No. .....

City St. Louis (If not in incorporated city or town give township) 4360 A Lore St. ..... Ward)

2. FULL NAME Rosa Wilhelm

(a) Residence. No. 4360 Delose St., 16 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 OF (OR) WIFE OF John Wilhelm

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-5-1868

7. AGE Years 60 Months 2 Days 26 If LESS than 1 day, ... hrs. or ..... min.

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) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Hungary
(STATE OR COUNTRY) .....

PARENTS

10. NAME OF FATHER Ernst Wilhelm

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

12. MAIDEN NAME OF MOTHER Barbara Ferber

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

14. INFORMANT John Wilhelm
(Address) 4366 Delose St.

15. FILED APR -3 1928, 19..... Ray C. Stoner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 1 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) N.M.A.
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED No
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. W. Keener, M.D.
(Address) Dep. Coroner

*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 Missouri Crematory — DATE OF BURIAL April 3 1928

20. UNDERTAKER Frenden & Co — ADDRESS 1718 Lo 9

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.