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

Do not use this space.

18481

1. PLACE OF DEATH

County ..... Registration District No. 791

Township St Louis ..... Primary Registration District No. 1003

City St Louis Mo. (No. Mo Baptist Sanitarium St. ..... Ward)

File No. ..... Registered No. 4828

2. FULL NAME Katherine Linke

(a) Residence. No. 1817 California ave St. 23 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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	Widowed.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 11 - 1839

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	88.	8	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) .....
(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER John Hoffmeister

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

12. MAIDEN NAME OF MOTHER Dont know.

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

14. INFORMANT Mrs. Julia Stoch
(Address) 1817 California ave.

15. FILED ..... 19 ..... Mary C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1928, to May 2, 1928, that I last saw her alive on May 29, 1928, and that death occurred, on the date stated above, at 11 - A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute Bronchitis
Due to fall to floor
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Fracture of left hip
Accident!
(duration) ..... yrs. ..... mos. - ds.

18. WHERE WAS DISEASE CONTRACTED? —
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & X Ray
(Signed) Harry H Meyer, M. D.
5/3, 1928 (Address) 4903 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 Old St Marcus. — DATE OF BURIAL May 5 1928

20. UNDERTAKER Ky Leidner Und Co — ADDRESS 1417 N. Market St

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.

THIS IS A PERMANENT RECORD