

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo.** (No. **Lutheran St. Loft**)

18569

File No.

Registered No. **4932**

St. Ward)

2. FULL NAME

Mathilda Abe

(a) Residence. No. **3422 Ohio Ave.** St. **24** 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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 28-1883.**

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
44	4	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House Wife**

(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

Carl Rader

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Germany**

12. MAIDEN NAME OF MOTHER

Maria Markon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Germany**

14.

INFORMANT **Albert Abe**
(Address) **3422 Ohio Ave.**

15.

FILED **MAY -6 1928**
REGISTRAR **Max C. Stankov**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 5- 1928.**

17. I HEREBY CERTIFY That I attended deceased from **4/26/28** to **5/3/28** that I last saw **alive** on **5/3/28** and that death occurred, on the date stated above, at **St. Louis, Mo.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fibro Myoma
546 D. Uterus - non
alignant
Pre-operative
Removal of Uterus
13 (duration) **2** yrs. **2** mos. **2** da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 **13** **28** **yes** DATE OF **5/3/28.**

WAS THERE AN AUTOPSY.....

WHEN TEST CONSIDERED SUFFICIENT **Johnnie Exam**

9 (Signature) **Johnnie Exam** M. D.
13 , 1928 (Address) **8958 S. Grand St**

*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

Sunset Burial Pk. May 6 1928

20. UNDERTAKER

Zeigender Bros. 26 N. 1st St.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

