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

Do not use this space.

18928

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 5338

City St. Louis Mo (No. ....., 5222 Idaho Ave St. ..... Ward)

2. FULL NAME Marie Seckinger

(a) Residence. No. ..... St., 15 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 1905

7. AGE: Years 22 | Months 8 | Days 28 | 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: At Home

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

PARENTS
10. NAME OF FATHER: Frank X Seckinger
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Louis (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER: Margaret Ising
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis (STATE OR COUNTRY) Mo

14. INFORMANT: Frank X Seckinger
(Address) 5222 Idaho Ave

15. FILED 15 1928 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 1928

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1928, to May 12, 1928, that I last saw her alive on May 12, 1928, and that death occurred, on the date stated above, at 8:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary tuberculosis

23A 31

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Joseph L Ferris, M.D.

5/14, 1928 (Address) 313 3d Meramec

*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: S.S. Peter & Paul Cmt | DATE OF BURIAL: May 16 1928

20. UNDERTAKER: McJ. Robert | ADDRESS: 1905 S Grand Blvd

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.