

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

Do not use this space.

19063

**1. PLACE OF DEATH**

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

Registration District No. **791**  
**1003**

File No. ....  
Registered No. **5481**  
Ward.....

**2. FULL NAME**

*Josephine Fester (FESTOR)*  
(a) Residence. No. *823 1/2 N. 9th St.* St. *Ward 12*

(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)** *May 1 1884*

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*7-4*      *17*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Retired*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Houseworker*  
(c) Name of employer

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

**10. NAME OF FATHER** *John Fester*

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

**12. MAIDEN NAME OF MOTHER** *Madeline Cornack*

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

**14. INFORMANT** *Mrs. Ignace de Loyola*  
(Address) *2209 Hebert*

**15. FILED** *MAY 20 1928* *Max C. Parker* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *May 18 8:40<sup>am</sup> 1928*

**17. I HEREBY CERTIFY**, That I attended deceased from *May 2*, 1928, to *May 18*, 1928 that I last saw her alive on *May 18*, 1928, and that death occurred, on the date stated above, at *8:40<sup>am</sup>* m.

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

*Chronic Myocarditis*  
*Chronic Bronchitis*  
*non Tubercular*  
CONTRIBUTORY (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**19. DID AN OPERATION PRECEDE DEATH?** *No.* DATE OF.....

WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical Examination*  
(Signed) *Anthony A. Prekarski, M.D.*

*5/19 1928* (Address) *1502 Cass Ave.*

\*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** *Mount Olivet* **DATE OF BURIAL** *5/21 1928*

**20. UNDERTAKER** *Hoffmeyer & Co* **ADDRESS** *7815 Bldg*

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.

