

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

Do not use this space.

19212

1. PLACE OF DEATH

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

Registration District No. 791
Primary Registration District No. 1003
(No. Mullamphy Hospital)

File No.....
Registered No. 5639
St..... Ward)

2. FULL NAME Marilyn Herchenroeder,

(a) Residence. No. 5643 Roosevelt Pl. St., 6 Ward.
(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. (If nonresident give city or town and State)

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 7, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min. 16

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Clifford Herchenroeder,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis,
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Mabel Flachmeier,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis,
(STATE OR COUNTRY) Mo.

14. INFORMANT Clifford Herchenroeder,
(Address) 5643 Roosevelt Pl.

15. FILED 24 1928 May 24 1928
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 19 28

17. I HEREBY CERTIFY That I attended deceased from May 7, 1928, to May 23, 1928 that I last saw her alive on May 23, 1928, and that death occurred, on the date stated above, at 7:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Infarction
157 C (congenital heart lesion)
9 Y B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

POW (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

19. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Thorsten Green, M. D.
, 19 (Address) 5435 1/2 Wash.

*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.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Walhalla Cem May 24 19 28

20. UNDERTAKER ADDRESS
Geo L. Pleitich
596 1/2
W. 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.

Dr. Zeeber
5435th E. 100th