

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

Do not use this space.

22427

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis, Mo.* (No. *City* Sanitarium)..... St. Ward)

File No.
 Registered No. **6619**

2. FULL NAME

Jennie Sassenrath
 (a) Residence, No. *Wellston Mo.* St. *13* Ward. *Wellston Mo.*
 (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 *Christian Sassenrath*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 49
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Housewife*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Bridgeton*
 (STATE OR COUNTRY) *Missouri*
 10. NAME OF FATHER *Unknown*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown*
 (STATE OR COUNTRY) *Missouri*
 12. MAIDEN NAME OF MOTHER
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
 (STATE OR COUNTRY) *Missouri*

14. INFORMANT *Joseph H. Stahl*
 (Address) *57 3/4 Grand*
 15. FILED *21* 19*21* REGISTRAR *May C. Stanley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6/23/26* 19
 17. I HEREBY CERTIFY, That I attended deceased from *11/1/27* 19... to *6/23/26* 19... (that I last saw him/her alive on *4/2/26* 19... and that death occurred, on the date stated above, at *3:25 p.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Abuse of lung (Pneumonia)
non tubercular cause unknown
 18413
 10701
 (duration) yrs. *6* mos. *11* da.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF *No*
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Laboratory*
 (Signed) *Joseph H. Stahl*, M. D.
6/23/26, 19 (Address) *5300 Grand*

*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 DATE OF BURIAL *6/25/28*
 20. UNDERTAKER *St. Marys Bridgeton* ADDRESS *5525*
Wm. H. Stuart *Easton Ave*

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.

