

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

Do not use this space.

35318

1. PLACE OF DEATH

County.....

Registration District No.....

791

Towship.....

Primary Registration District No.....

1003

City.....

(No.) *St. Louis Mo.* (No.) *Sanitarium*

File No.....

Registered No.....

2. FULL NAME

Annie Gulben

(a) Residence. No. *2027* *Eugenia* St., *13* Ward.

Length of residence in city or town where death occurred *134* yrs. *2* mos. *2* 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)

Unknown

7. AGE

about 67

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Servant

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

"

14.

INFORMANT
(Address)

*Louise Gulben
5300 Manual*

15.

FILED

*1913
Maul Starvoff
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/20/26* 19

17. I HEREBY CERTIFY, That I attended deceased from *7:15*, 19*26*, to *10:20*, 19*26*, that I last saw him alive on *10/20/26*, 19*26*, and that death occurred, on the date stated above, at *2:45 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Broncho-pneumonia
197A
115B / 105 W*

CONTRIBUTORY *Absence of Parotid Gland (Glymphoma)*
(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*
(Signed) *Louise Gulben*, M.D.
10/20/26, 19 (Address) *5300 Manual*

*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

Cemetery

Oct 22 1926

20. UNDERTAKER

E. J. Schum

ADDRESS

3125 Lafayette

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.

RECORD WITH OBTAINING INFO—THIS IS A PERMANENT RECORD

