

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

Do not use this space.

42559

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No. ....

Registered No. **11800**

**2. FULL NAME**

(a) Residence No. **145 Howard St** Ward **26**

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **25** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

SEX **Female** COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mr. [unclear]**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 22 1863**

7. AGE YEARS **65** MONTHS **4** DAYS **17** If LESS than 1 day, hrs. or min.

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) (STATE OR COUNTRY) **Tennessee**

10. NAME OF FATHER **Not known**

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) **City Hospital**

15. FILED **1 1928** **W. C. Stankoff** REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 7 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Nov 29**, 19**28**, to **Dec 3**, 19**28**, that I last saw him alive on **Dec 3**, 19**28**, and that death occurred, on the date stated above, at **1245 a**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Hypostatic Lobar Pneumonia (Lft)**  
**Ch. meningitis**  
**108** (duration) yrs. mos. ds. **10**

CONTRIBUTORY **93C** (SECONDARY) (duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS (Signed) **R. Berg**, M. D.

**12/3** 19**28** (Address) **City Hospital**

\*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 **New Bethelam Cem.** DATE OF BURIAL **Dec 6 1928**

20. UNDERTAKER **Thos. W. Beidaweden** ADDRESS **1936 St. Louis 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.

Elbrick  
Albright .