

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

Do not use this space.

42744

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

Township.....

Primary Registration District No.

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

File No.

Registered No. **12000**

St.

Ward)

2. FULL NAME

(a) Residence. No. **2301/2 Madison St. 20** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **69** 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 (use the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan 27 - 1859

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

69 | 10 | 16

8. OCCUPATION OF DECEASED

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

nurse

(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)

Missouri

10. NAME OF FATHER

Louis Katz

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Emilie Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT

(Address)

**St. Louis
City / Hospital**

15. FILED

19 **10 29**

Wm C. Frankoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec 8 1928

17.

HEREBY CERTIFY That I attended deceased from

Oct 27 1928 to Dec 8 1928
that I last saw him alive on **Dec 8 1928**, and that death occurred, on the date stated above, at **10 10** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

carcinoma of the parotid gland
53E
93C (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Chronic Myocarditis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

49
IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **John M. Stutz** M. D.
1210, 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

DATE OF BURIAL

St. Peters & Paul

Dec. 11, 1928

20. UNDERTAKER

ADDRESS

**1417
164 Leidner Und 608 N. Market**

WRITE PAINLY, 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.

Atterbaek