

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

Do not use this space.

42940

781

0003

1. PLACE OF DEATH

County.....

Registration District No.....

File No.....

Township.....

Primary Registration District No.....

Registered No.....

City..... *St. Louis* (No. *5077* *Washington* Block).....

Ward.....

2. FULL NAME

Marie Troelicht

(a) Residence. No. *422 Laurel St.*..... *5* Ward.....

(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 MEDICAL CERTIFICATE OF DEATH

3

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White

single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown 1888*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

abt. 40

8. OCCUPATION OF DECEASED

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

at Home

(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)

St. Louis

10. NAME OF FATHER

Edw Troelicht

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

12. MAIDEN NAME OF MOTHER

Belle Blank

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

14. INFORMANT

Mrs Edw Troelicht

(Address)

422 Laurel St

15. FILED

DEC 15 1928

Max E. Starker

REGISTRAR

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

12/14 1928

17.

I HEREBY CERTIFY, That I attended deceased from *12:00*....., 19*28*.., to *6:00*....., 19*28*.., and that I last saw him..... alive on *Nov. 12*....., 19*28*.., and that death occurred, on the date stated above, at..... *8:00*..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

transition. general.

69 B. pneumonia

78

(duration)..... yrs. *8*..... mos. da.

CONTRIBUTORY (SECONDARY)

Pneumonia (Pneumia)

(duration)..... yrs. *7*..... mos. da.

18. WHERE WAS DISEASE CONTRACTED

mostly at vacation, manila

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?

no DATE OF.....

20. WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS?

Had known several medical men

(Signed).....

Louis H. Starker

M. D.

Dec. 12, 1928 (Address) 62 No Broadway

*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

Cabany

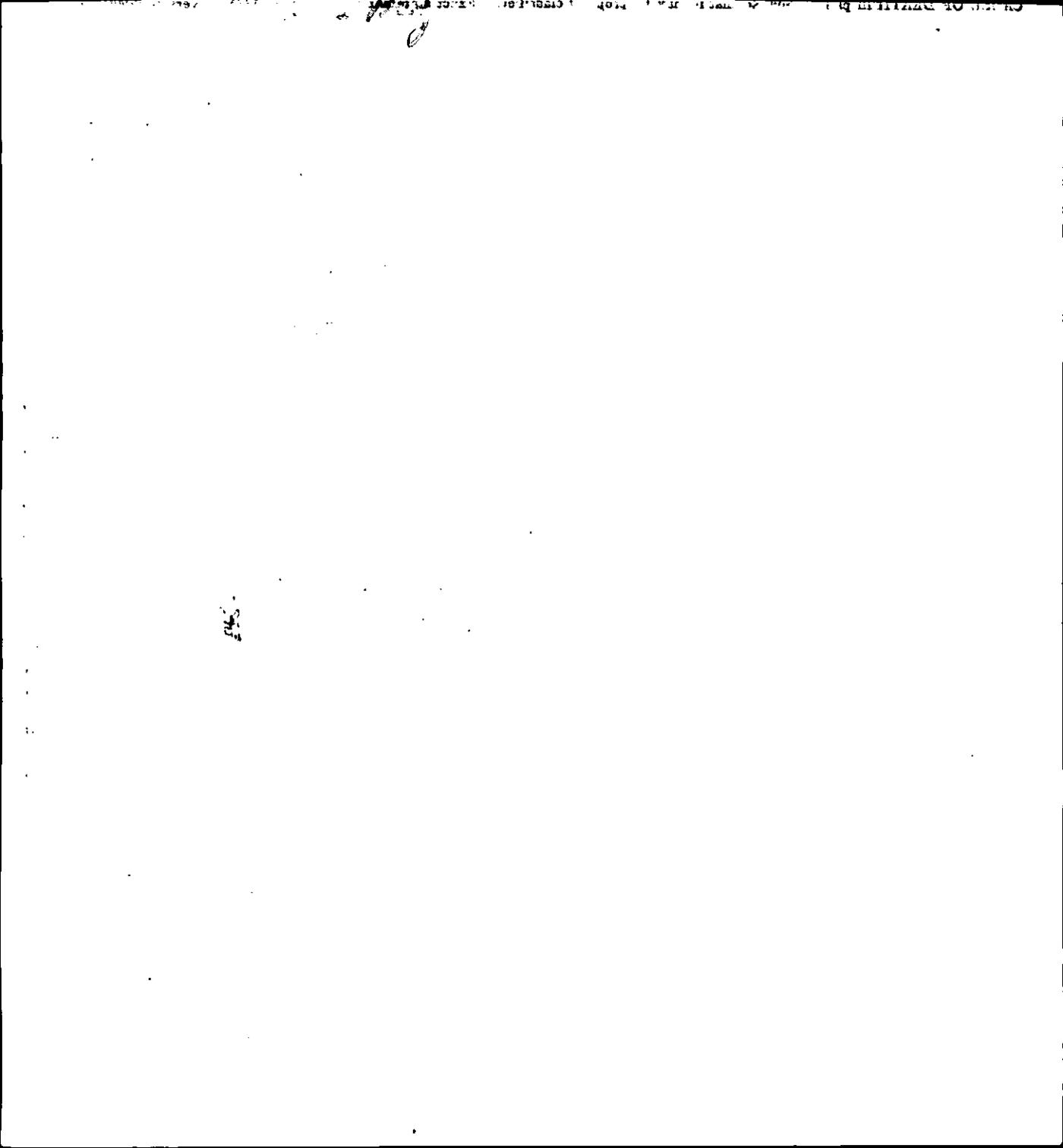
12-17 1928

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly

2039 Wash St



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 42940
 Township..... Primary Registration District No. 1003 Registered No. 12210
 City St. Louis (No.) St. Ward.....

2. FULL NAME Marie Troelicht

(a) Residence. No. St. Ward. (If nonresident give city or town and State)
 (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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>M</u> (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/14 1928

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Transition general
acidosis
diabetic information given
see phone by Dr. P. Behrens
 CONTRIBUTORY law of W.D. 2-14-29 (duration) yrs. mos. ds.
 (secondary)

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19 (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 19

20. UNDERTAKER ADDRESS

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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)
Max C. Farloff

15. FILED FEB 14 1929 Max C. Farloff REGISTRAR

SUPPLEMENTARY

69B

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Exact statement of OCCURRENCE in very important cases must be properly classified. Exact statement of OCCURRENCE in very important cases must be properly classified.

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