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.

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

Do not use this space.

43248

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 2019, Menard St. ..... Ward)

File No. ..... Registered No. 12555

2. FULL NAME Catharina Azenhofer

(a) Residence. No. 2019 Menard St., 23 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

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: William Azenhofer

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 1 - 1906

7. AGE: Years 22, Months 3, Days 20. If LESS than 1 day, ... hrs. or ..... min.

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): Housework

(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN): Austria
(STATE OR COUNTRY): Hungaria

PARENTS

10. NAME OF FATHER: Frank Schmitz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Hungaria

12. MAIDEN NAME OF MOTHER: Susana Hoie

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Hungary.

14. INFORMANT: William Azenhofer
(Address) 2019 Menard St.

15. FILED 21 1928 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 21 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(Non traumatic)
82 Dr
74 a/
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

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

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

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner, M.D.

12/22, 1928 (Address) Dep. Coron

*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 St Marcus Cemetery

DATE OF BURIAL: Dec 24 1928

20. UNDERTAKER: J H Gebken 2630 Gravois Av.

ADDRESS