

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

Do not use this space.

43654-84

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.* (No. *2345 1/2 St. Market St.*)

File No.

Registered No. **9**

St.

Ward)

2. FULL NAME *Mary E. Holtmann*

(a) Residence. No. *2345 1/2 St. Market St.* **L0** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

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 *Henry Holtmann*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 3 - 1862*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 6 28

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)

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

10. NAME OF FATHER *Ernst Kensiak*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Germany*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Marie Drosselner*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Germany*
(STATE OR COUNTRY)

14. INFORMANT *Henry Holtmann*
(Address) *2345 1/2 St. Market St.*

15. FILED *IAN - 1, 1929* *Max C. Taylor*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 31 - 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 8*, 1928, to *Dec 31*, 1928, that I last saw her alive on *Dec 28*, 1928, and that death occurred, on the date stated above, at *1 - A.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92A acute dilatation of heart
95B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Chronic Endocarditis*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *100A*
IF NOT AT PLACE OF DEATH

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

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *D. A. Thomson* M. D.
Dec 31 1928 (Address) *312 W. Spruce*

*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 *Shew. Pickers* DATE OF BURIAL *Jun 3 1929*

20. UNDERTAKER *Hy Leidner* ADDRESS *1417 1/2 St. Market*

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.

