

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

Do not use this space.

43654-517

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City *St. Louis*

(No. *5041*, *Idaho*)

File No.....

Registered No. *21*

St. Ward)

2. FULL NAME

Anna M. Spath

(a) Residence, No. *5041 Idaho* St., *15* 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)

Single

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

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

Mar 3-1870

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>58</i>	<i>9</i>	<i>27</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Dry Goods & Notions*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Proprietor*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *St. Louis County Mo.*

10. NAME OF FATHER

William Spath

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER

Elizabeth Spahn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

14.

INFORMANT *Wm. M. Spath*
 (Address) *5041 Idaho ave*

15.

FILED *2-1-1929* REGISTRAR *Wm. C. Storker*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 30th 1928*

17. I HEREBY CERTIFY, That I attended deceased from *July 10*, 1928, to *Dec 30*, 1928 that I last saw her alive on *Dec 30*, 1928, and that death occurred, on the date stated above, at *8:45 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

50
Carcinoma of Breast (duration) yrs. *5* mos. *21* ds.
 CONTRIBUTORY *Carcinoma Breast* (SECONDARY) (duration) yrs. *5* mos. *21* ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH *477*
 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *July 17 1928*
 WAS THERE AN AUTOPSY? *no*
 WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Laboratory*
 (Signed) *D. M. Gibson*, M. D.
12/31, 1928 (Address) *4337 Washington Bl*

*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. Trinity Lutheran | *Jan. 2-1929*

20. UNDERTAKER | **ADDRESS**

Witt Bros L & Co 2929 St. Jefferson

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.

