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

Do not use this space.
3677

1. PLACE OF DEATH

County..... Registration District No. 791

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

City St. Louis (No. 2706 S. Jefferson Ave. St. ..... Ward)

File No. ..... Registered No. 275

2. FULL NAME Selina Steinhauer

(a) Residence. No. 2706 S. Jefferson Ave. St., 23 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 26th. 1886.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
42	3	10	

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) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

PARENTS

10. NAME OF FATHER Henry Diehl

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

12. MAIDEN NAME OF MOTHER Rose Urberger

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

14. INFORMANT Otto Steinhauer
(Address) 2706 S. Jefferson Ave.

15. FILED ..... 1929 Wm C Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 5th. 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Jan 5, 1929, that I last saw h. on alive on Jan 5, 1929, and that death occurred, on the date stated above, at 2 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia.
Pa 59
R. E. Hart

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY) Diabetes mellitus.

..... (duration) ? yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Home

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab.

(Signed) Walter M. Jones, M. D.

1-5, 1929 (Address) 3400 Gravois

*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 — DATE OF BURIAL Jan. 8 1929

20. UNDERTAKER Wacker-Helderle — ADDRESS 2331 S. Broadway

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.

235
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