

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

Do not use this space.

9042

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township St. Louis Primary Registration District No. 1003 File No. 2773  
 City St. Louis (No. Exposures to City Hospital) Registered No. 2773 Ward

**2. FULL NAME**

(a) Residence. No. 1530 Gateway Ave St. 13 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 1 - 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
70 7 11 27 2 1 2

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House Work  
 (b) General nature of industry, business, or establishment in which employed (or employer) at home  
 (c) Name of employer

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. George W. Gross  
 (Address) 3429 Vista

15. FILED 149 - 2 1929 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28 1929

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 ..... 9-12 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

99C  
Chronic Myocarditis  
~~.....~~ yrs. mos. da.

CONTRIBUTORY (SECONDARY) 90B (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH..... DATE OF..... WAS THERE AN AUTOPSY..... No

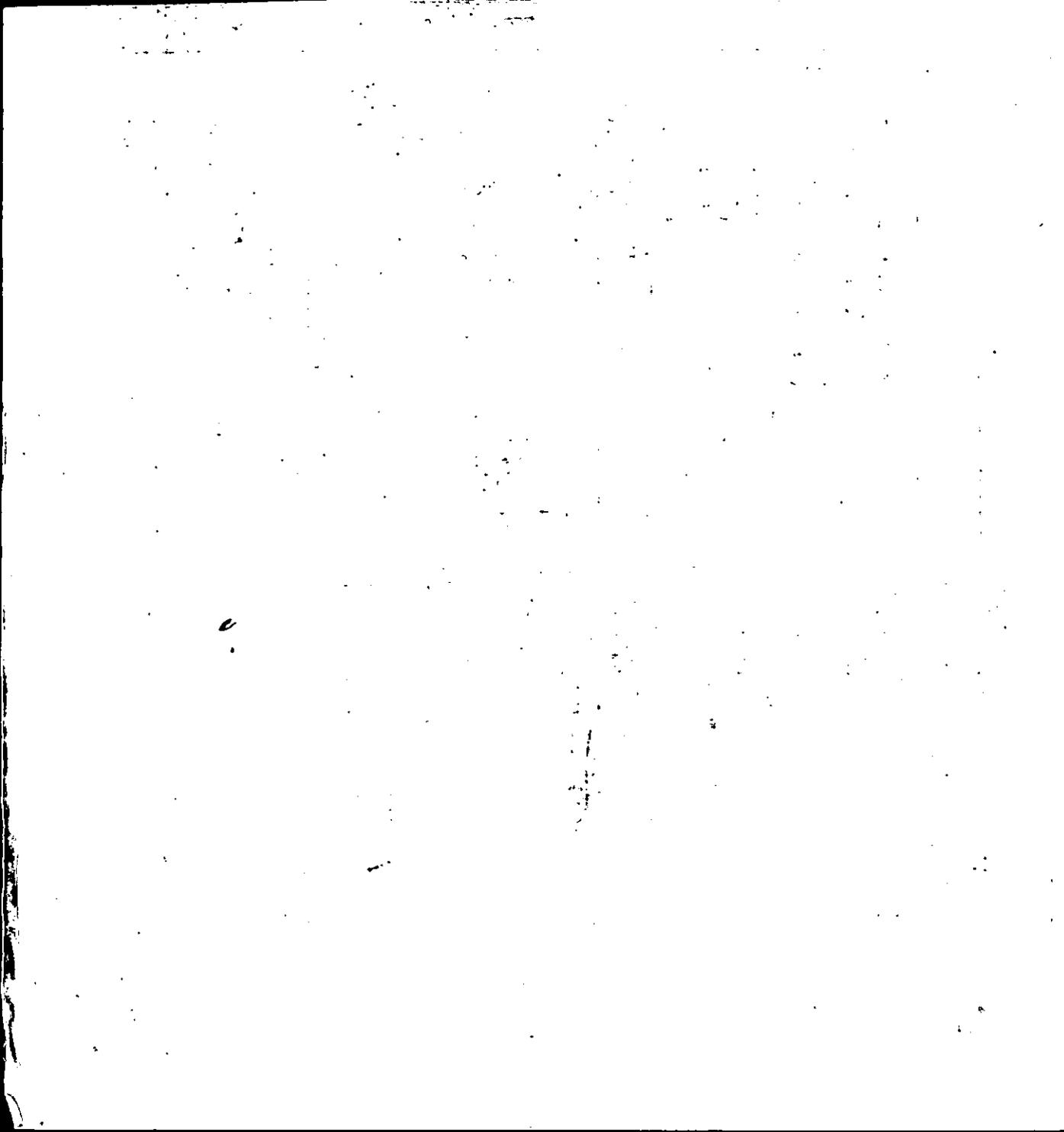
WHAT TEST CONFIRMED DIAGNOSIS (Signed) Dr. Shubert 3/2 1929 (Address) Dr. Shubert's Office

\*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 St. Paul Churchyard DATE OF BURIAL Feb 28 1929

20. UNDERTAKER Edw. P. Howard & Son ADDRESS 4212 St. Louis Ave

23 Sta-4-28 - 11-27  
 # 7 corr by supp



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

9042

**1. PLACE OF DEATH**

County..... Registration District No. 491  
 Township St Louis Primary Registration District No. 1003  
 City St Louis (No. ....) St. .... Ward)

File No. ....  
 Registered No. 2773

**2. FULL NAME**

(a) Residence. No. .... St. .... 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.

Mary Duweel

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 19 29

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 1-1858

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
70 11 27

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration)..... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration)..... yrs. .... mos. .... ds.  
 (c) Name of employer

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

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

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)

\*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.

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) .....

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

19

15. JUN -6 1929 Mary C Stanley REGISTRAR

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL ARE COMPLETE AS PREC. CAUSE OF DEATH in plain terms, so that it may be properly classified. AG. Every item of information furnished is to be entered EXACTLY. PHYSICIAN'S SIGNATURE and OCCUPATION.

SUPPLEMENTARY

S-9042