

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

Do not use this space.

9687

1. PLACE OF DEATH

County Buchanan
Township
City St. Joseph Mo (No. 2714 South 19th)

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 375
St. _____ Ward

2. FULL NAME Alma Fritz Merkle

(a) Residence. No. 2714 South 19th 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.

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 Joseph Merkle

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 10 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66 | 2 | 14

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) Wurtemberg
(STATE OR COUNTRY) Germany

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mr. Joseph Merkle
(Address) 2714 South 19th

15. FILED 25 1929
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 24, 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1928, to March, 1929, and that I last saw her alive on March 21, 1929, and that death occurred, on the date stated above, at 1:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of stomach

468 (duration) 1 yrs. 0 mos. 0 ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS clinical and xray
(Signed) J. [Signature], M. D.

3/25, 1929 (Address) St. Joseph Mo.

*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 Ashland DATE OF BURIAL Mar. 27 1929

20. UNDERTAKER Sheeman Funeral Home ADDRESS 1208 Francis

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.

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x. A. J. Mason.