

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

Do not use this space.

12154

PLACE OF DEATH  
County St. Louis  
Township Central  
City (No. ....) .....

Registration District No. 289  
Primary Registration District No. 6033A

File No. ....  
Registered No. 87  
St. .... Ward .....

2. FULL NAME Anna C. Bueckaldt  
(a) Residence No. Olivette Mo. 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. 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 The late George Bueckaldt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-29

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>78</u>		<u>2</u>	<u>12</u>	<u>4</u>

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

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

10. NAME OF FATHER Geo. Werner

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Mrs. G. R. Schmidt  
(Address) 2616 Tennessee Ave

15. FILED 3/13 1929 Rolla Gray M.D. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 11 1929

17. I HEREBY CERTIFY, That I attended deceased from 6th 1929, to March 10 1929  
and I last saw him alive on March 10 1929, and that death occurred, on the date stated above, at 6:10 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Arteriosclerosis Chron.  
interstitial nephritis and  
chronic myocarditis 131

CONTRIBUTORY (SECONDARY) None 930

18. WHERE WAS DISEASE CONTRACTED 124 W 97  
IF NOT A PLACE OF DEATH .....

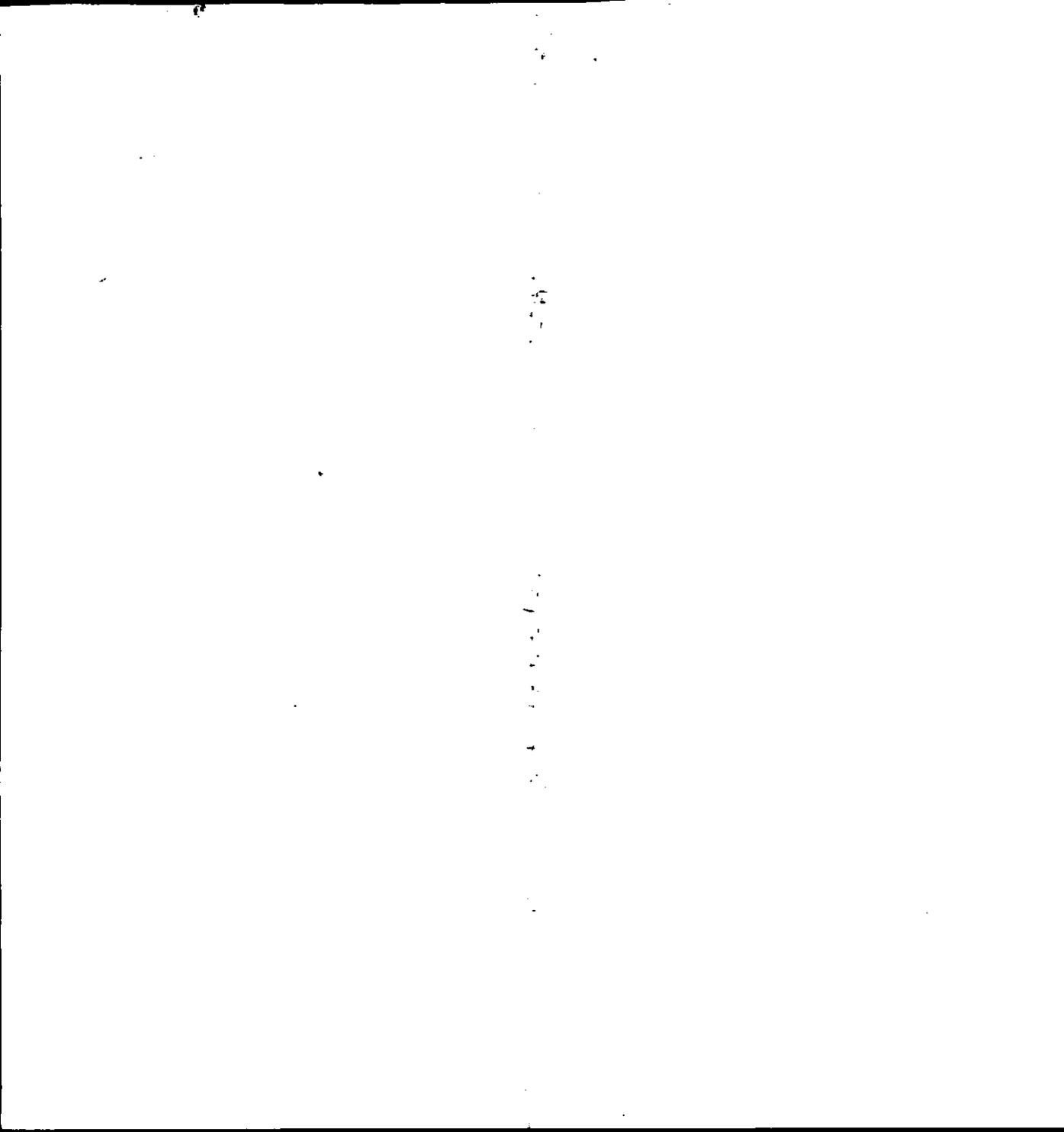
DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) E. P. Achler M. D.  
3/12 1929 (Address) 802 Metropolitan Bldg.

\*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 <u>St. Peters Cemetery</u>	DATE OF BURIAL <u>March 14</u> 19 <u>29</u>
20. UNDERTAKER <u>H. Lechner Und Co.</u>	ADDRESS <u>1417 N. Market St.</u>



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County, St. Louis Registration District No. 789 File No. ....  
Township, Central Primary Registration District No. 6033 B Registered No. 87  
City, ..... (No. .... St. .... Ward)

**2. FULL NAME**

Anna C. Beckrodt

(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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 29 1850

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

**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.....

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

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)

15. FILED 3/13 1929 Anna C. Beckrodt REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 11 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..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

**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.

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

20. UNDERTAKER ADDRESS

REGISTRATION SHALL NOT RECEIVE A FEE FOR THIS CERTIFICATE UNTIL THEY ARE COMPLETE AS FOR DEATH IN plain terms, so that it

SUPPLEMENTARY

5-12/54