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

Do not use this space.

12579

1. PLACE OF DEATH

County ..... Registration District No. 79 ..... File No. .....

Township ..... Primary Registration District No. 1003 ..... Registered No. 3107

City St Louis (No. 5800 Arsenal St. ..... Ward)

2. FULL NAME Rosie Wilson

(a) Residence. No. 1529 Franklin St., 25 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U.S., if of foreign birth? 79 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE abt YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
80	?	?	

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

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

PARENTS

10. NAME OF FATHER Max Wuench

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Marie Effinger
(Address) City Infirmary

15. FILED 12 1929, 19 ..... Max C. Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/10 1929

17. I HEREBY CERTIFY, That I attended deceased from 3/1 ....., 1929, to 3/10, 1929 that I last saw her alive on 3/10, 1929, and that death occurred, on the date stated above, at 6:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93C
99A
(duration) 7 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage
(duration) 5 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? .....
(Signed) Bil Kiehbiel, M.D.
3/11, 1929 (Address) 5600 Arsenal

*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 Mathews — DATE OF BURIAL Mar 13 1929

20. UNDERTAKER Grove Mud Co — ADDRESS 3710 N Grand

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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