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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 12652

Township ..... Primary Registration District No. 1003 Registered No. 3186

City St. Louis, Mo. (No. 5600 Arsenal St. 24th Ward)

2. FULL NAME Katherine Ihle Maria

(a) Residence. No. 2717 a Glasgow St., 20 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4 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	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 27 - 1919

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	10	0	14	

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

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

PARENTS

10. NAME OF FATHER James -

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

12. MAIDEN NAME OF MOTHER Mary, Ipelino

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

14. INFORMANT Mrs. May Hedrick
(Address) Isolation Hospital

15. FILED ....., 19.. Max [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/13 1929.

17. I HEREBY CERTIFY, That I attended deceased from 2/28, 1929, to 3/13, 1929 that I last saw her alive on 3/13, 1929, and that death occurred, on the date stated above, at 7.45 A.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Diphtheria Pharyngeal + Nasal
Septic Sore Throat

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (SECONDARY) Myocarditis, Acute.

(duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 2717 a Glasgow
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Culture
(Signed) [illegible], M. D.
3/13, 1929 (Address) 5600 Arsenal St.

*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
Calvary	Mar 15 1929
20. UNDERTAKER	ADDRESS
Bensick & Nicholas	1138 N 6th

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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