

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

Do not use this space.

13364

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. 1800 Wagoner Pl)
 St. _____ Ward _____

File No. _____
 Registered No. **3940**
 St. _____ Ward _____

2. FULL NAME

Veronica Roth
 (a) Residence. No. 1800 Wagoner Pl St. 11 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) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 2 - 1840

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
88 6 29

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) " "
 (c) Name of employer

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

10. NAME OF FATHER Hy Baker
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ger
 12. MAIDEN NAME OF MOTHER Unkner
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ger.

14. INFORMANT Mrs Lena Bauwau
 (Address) 1800 Wagoner Place

15. FILED 11 1929 Max Stumpp REGISTRAR

E MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 31 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1929 to Mar 31 1929 that I last saw h. or alive on March 12 1929 and that death occurred, on the date stated above, at _____ p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
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Senility
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Ch. Myocarditis
 (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) Dr. Robert P. ... M. D.

March 31 1929 (Address) 4968 Delmar Blvd

*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 Pull No DATE OF BURIAL April 29

20. UNDERTAKER Bronschweig & ... ADDRESS 4740 2nd

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.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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