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

16000

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 4022

City St Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME 1976 Lydia Munsinger

(a) Residence. No. 4923 Harney St. 7 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 57 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 4 1871

7. AGE Years 57 Months 10 Days 30 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(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) Missouri

PARENTS

10. NAME OF FATHER Felix Herman

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

12. MAIDEN NAME OF MOTHER Charlotte Sprooker

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

14. INFORMANT Hospital Informant
(Address) E Kinney City Hospital

15. FILED ..... 19 ..... Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 3, 1929, that I last saw h.. alive on April 3, 1929, and that death occurred, on the date stated above, at 9:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Pulmonary Tuberculosis
220
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31
(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? X ray

(Signed) Edward J Helbing M.D
4/4, 1929 (Address) City Hospital

*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 Peters DATE OF BURIAL April 6 1929

20. UNDERTAKER Math Hermann & Son ADDRESS 2161 Fair Av

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.