

**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**
 Township..... Primary Registration District No. **1003**
 City, **St. Louis** (No. **4333**) **Neosho St.** St. _____ Ward _____

File No. **16031**
 Registered No. **4059**

2. FULL NAME

(a) Residence. No. **4333** **Neosho** St., **15** 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

1/3. SEX **Female** | 4. COLOR OR RACE **white** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb 22, 1872**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	57	1	12	

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

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo.**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Charles Oberfoell**

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

12. MAIDEN NAME OF MOTHER **Mary Kiesel**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Belleville Ills.**
 (STATE OR COUNTRY)

14. INFORMANT **Charles Dlg**
 (Address) **4333 Neosho St.**

15. FILED **Mar C Starbuck** 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 **Sept 25**, 1928, to **April 3**, 1929 that I last saw her alive on **April 23**, 1929 and that death occurred, on the date stated above, at **550 P**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lymphangoma
Post peritoneal Lymph
glands (duration) **1** yrs. mos. ds.
 CONTRIBUTORY **545**
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____

1 DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **Oct 1 - 1928**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Operation**

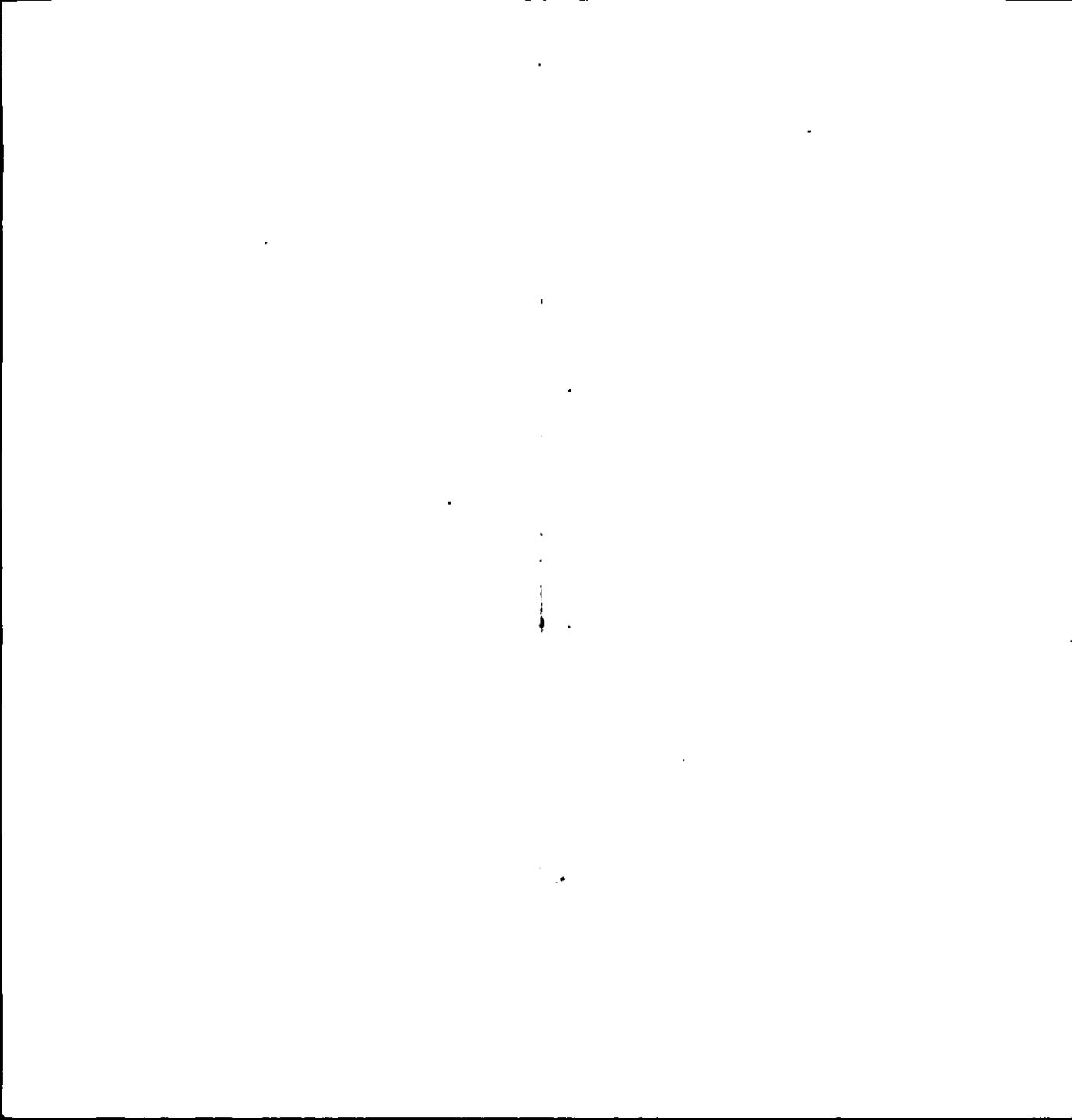
(Signed) **Adam G Youngman M.D**
 , 1929 (Address) **5439 Broadway**

*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 **Sun Set Burial Park** DATE OF BURIAL **April 16 - 1929**

20. UNDERTAKER **Mrs Kutes** ADDRESS **2906 Crovois Ave.**

PARENTS



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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. 991 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 4059
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME

Addeline Dlg
 (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) m

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

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

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 _____
 (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) _____

PARENTS	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 1029 1929 St. Louis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 9 1929

17. I HEREBY CERTIFY That I attended deceased from _____
 19____ to _____, 19____
 that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lymphangiomatous
lymphatic degeneration
of the heart by Dr. Adam Youngman
Phys. of U. S. G. - 25-29 yrs. mos. ds.

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) Adam Youngman, 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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY 500

S-16031