

**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. 5925) Sarasche Ave St. _____ Ward _____

File No. 16260
 Registered No. 4299

2. FULL NAME

(a) Residence. No. 5925 Sarasche Blvd. 7 Ward. (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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Leo B. Werne, Jr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 15 1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 11 25

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) St. Louis
 (STATE OR COUNTRY)

10. NAME OF FATHER Charles Robinson

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

12. MAIDEN NAME OF MOTHER Adelaide Sandborg

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

14. INFORMANT Charles Robinson
 (Address) 5925 Sarasche Blvd

15. FILED 12 1929 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1926 to April 10, 1929
 that I last saw h..... alive on April 10, 1929 and that death occurred, on the date stated above, at 3:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Endocarditis
92A
166A
958 (duration) 2 yrs. 6 mos. ds.
 CONTRIBUTORY Anti-Bromides Anti
 (SECONDARY)
regulator of heart (duration) yrs. mos. 5 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? Clinical
 (Signed) J. W. McDonald, M. D.

(Address) 3529 Franklin

*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. Rose of Lima DATE OF BURIAL Apr 13 1929

20. UNDERTAKER Matt. Hermann & Son ADDRESS 2161 E. Fair Ave

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

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.

2925

