

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

Do not use this space.

16278

1. PLACE OF DEATH

County..... Registration District No. 701
 Township..... Primary Registration District No. 1003
 City..... (No. 4431 So Broadway)

File No.
 Registered No. 4317
 St. Ward)

2. FULL NAME

(a) Residence. No. 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

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 14, 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 9 28

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) Germany

10. NAME OF FATHER Fro Munch

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

12. MAIDEN NAME OF MOTHER Phillippine Neke

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

14. INFORMANT (Address) W E Collins
4431 So Broadway

15. FILED 12 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1929, to Apr. 12, 1929 that I last saw her alive on Apr. 8, 1929 and that death occurred, on the date stated above, at 10:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
130 Chronic Interstitial Nephritis
93D

12 (duration) several years yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Gall Stones
asthma, rigidity
 (duration) 19 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

(Signed) Charles Tyndman M. D.

(Address) Beaumont Bldg

*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

Bell's Mortuary 4/13 1929

20. UNDERTAKER ADDRESS

W E Collins 2514 So Broadway

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.

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