

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

Do not use this space.

19550
5150

1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis* (No. *3745*, *Virginia* St. Ward)

Registration District No. *791*
Primary Registration District No. *1003*

File No.
Registered No.

2. FULL NAME

Amalia Weible

(a) Residence. No. *3745 Virginia* St., *27* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *30* yrs. - mos. - ds. How long in U.S., if of foreign birth? *50* yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 9 1859*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 *2* *26*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housework*
(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 *Fredrich Rode*

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

12. MAIDEN NAME OF MOTHER *Katharina Oetting*

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

14. INFORMANT (Address) *Emma Passer 3745 Virginia*

15. FILED *MAY -7 1929* REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 5 1929*

17. I HEREBY CERTIFY, That I attended deceased from *May 29* to *May 5 1929* that I last saw h.t. alive on *May 5 1929* and that death occurred, on the date stated above, at *8.20 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis

100 ft
111 ft (duration) yrs. mos. *1* ds.

CONTRIBUTORY (SECONDARY) *Leads to tubercle* (duration) yrs. mos. *50* ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *[Signature]* M. D.

97 19 *29* (Address) *2844 Oak*

*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 *Neo. St Marcus* DATE OF BURIAL *5-8 1929*
20. UNDERTAKER *W. Schumacher* ADDRESS *3013*

10-10-20 262

CAUSE OF DEATH in plain terms, so that it may be properly classified.

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