

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

Do not use this space.

19587

1. PLACE OF DEATH

County.....
Township.....
City..... (No. *City Hospital #1*)

Registration District No. **791**
Primary Registration District No. **1703**

File No.
Registered No. **5191**
St. Ward)

2. FULL NAME *MINNIE STAM*

(a) Residence. No. *2110 DEKALB* St., *23* 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) *WIDOWED*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *JULY 30 - 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *62 9 7*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *HOUSE WORK*
(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)

PARENTS
10. NAME OF FATHER *FRED. OTTE*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *GERMANY*
12. MAIDEN NAME OF MOTHER *LIZZIE KLUTE*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *GERMANY*

14. INFORMANT *LIZZIE McDONALD*
(Address) *2110 DEKALB ST*

15. FILED *MAY - 9 1929* *May C Starkoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *MAY 7 1929*

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Chronic Endocarditis*
(duration) yrs. mos. ds.

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

DID AN OPERATION PREVENT DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *J. W. Kenner, M.D.*
5/9 29 (address) *Dep. Coron*

*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 *NEW ST. MARCUS* DATE OF BURIAL *MAY 10 1929*

20. UNDERTAKER *74. TRUBE, UND Co* ADDRESS *1519 7455 ELL 131*

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.

10-9-29

