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.

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 File No. 19974

Township ..... Primary Registration District No. 1003 Registered No. 5617

City St. Louis (No. 1820 9 N. Leffingwell a St. ..... Ward)

2. FULL NAME Lena De Guentz

(a) Residence. No. 1820 9 Leffingwell a St. 20 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND~~ OF (OR) ~~WIFE OF~~ Maurice De Guentz

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 2 - 1897

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	32	4	10	

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) Mo

PARENTS

10. NAME OF FATHER Rudolph Geober

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

12. MAIDEN NAME OF MOTHER Ida Hobusch

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

14. INFORMANT Maurice De Guentz
(Address) 1820 9 N. Leffingwell a

15. FILED MAY 21, 1929 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1928, to May 20, 1928 that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at 11.30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Syphilis of brains

(duration) 17 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

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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) W B Bush M. D.
, 19 (Address) 437 Metropolitan 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: Calvary Cemetery — DATE OF BURIAL: May 23 1929

20. UNDERTAKER: Cullinane Bros — ADDRESS: 1710 N Grand Ave

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1
26
2

Mr. B. Bush
Metropolitan Bldg
10 to 1
7 to 8