

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

Do not use this space.

22969

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City: **St. Louis, Mo.** (No. **6319 Henry Ave.**) St. Ward)

File No.
 Registered No. **6395**

2. FULL NAME **Mae A. Rhoads**

(a) Residence. No. **6319 Henry Ave.** St. **2** 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)
Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 4 - 1905**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
23 **11** **9**

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)

10. NAME OF FATHER **August H. Overmann**

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

12. MAIDEN NAME OF MOTHER **Paula Stohmann**

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

14. INFORMANT **Mrs August Overmann**
 (Address) **6319 Henry Ave**

15. FILED **1929** **Mar 2** **Stark**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 13 - 1929**

17. I HEREBY CERTIFY, That I attended deceased from **July 21**, 19**29** to **June 13**, 19**29** that I last saw her alive on **June 13**, 19**29** and that death occurred, on the date stated above, at **7:10 P.M.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis (Pulmonary)

23 31 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **H. J. Kiehn**
6/14, 19**29** (Address) **3621 N. 20th**

*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 **Lakewood Park Cem** DATE OF BURIAL **6-15-1929**

20. UNDERTAKER **Ziegenhain Bros** ADDRESS **1623 Tucker St**

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.

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

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