

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

Do not use this space.

23158
File No. 6629
Registered No. St. Ward

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **4338 Johns Ave.**)

2. FULL NAME Amalia Joost

(a) Residence. No. **4338 John Ave.** St., **10** 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 **William A. Joost**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **5-24-1855**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 0 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House-wife**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer **at home**

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Germany**

PARENTS

10. NAME OF FATHER **Frederick Siebert**

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

12. MAIDEN NAME OF MOTHER **Eleanor Behrens**

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

14. INFORMANT **Mrs. Eva Placke**
(Address) **457 Waldige**

15. FILED **20** REGISTRAR **Max E. Stark**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6/19/29**
17. I HEREBY CERTIFY that I attended deceased from **11/19/29** at **St. Johns** and that I last saw him/her on **6/17/29** at **11 P** and that death occurred, on the date stated above, at **11 P** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dilatation of Heart
Chronic Myocarditis (duration) **1** yrs. **1** mos. **1** ds.
CONTRIBUTORY (SECONDARY) **6** yrs. **6** mos. **6** ds.

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

DID IN OPERATION PRECEDE DEATH **Yes** DATE OF **6/20/29**
WAS THERE AN AVIATOR **Yes**
WHAT TEST CONFIRMED DIAGNOSIS **Clinical Symptoms**
(Signed) **Chas. E. Mott**, M. D.
6/20, 1929 (Address) **3903 Lee Ave**

*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 **St. Johns Cem.** DATE OF BURIAL **6-28 1929**

20. UNDERTAKER **Alexander & Sons** ADDRESS **6675 Delmar**

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.

10 235

C. F. M...
3903 Lee Ave
4129 N.