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.

23457

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 6946

City St. Louis (No. St. Luke's Hospital ..... St. ..... Ward)

2. FULL NAME Sophie Stricker

(a) Residence. No. St. James MO St. 12 Ward. St. James Mo
(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: F

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) 1-16-1853

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
76	5	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(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

PARENTS

10. NAME OF FATHER: Unknown

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

12. MAIDEN NAME OF MOTHER: Unknown

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

14. INFORMANT L. J. Jones (Address) Steelville Mo

15. FILED ....., 19.. Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-30-1929

17. I HEREBY CERTIFY, That I attended deceased from June 23rd, 1929, to June 30, 1929 that I last saw her alive on June 30, 1929, and that death occurred, on the date stated above, at 3:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY) Hypertension

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

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? physical diagnosis

(Signed) Geo. H. Wood, M. D

, 19 (Address) St. Luke's Hosp.

*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. James Mo

DATE OF BURIAL: July 2 1929

20. UNDERTAKER: Alexander & Sons

ADDRESS: 6175 Delmar