

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

Do not use this space.

26133

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

St. Louis Mo.

(No. **3529**)

So. Jefferson Ave

File No.....

Registered No. **7330**

St.....

Ward.....

2. FULL NAME

(a) Residence, No. **3529 So. Jefferson** St., **24** 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male

White

married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Feb. 1 - 1866.

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

63

5

12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Physician

(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)

Ill.

10. NAME OF FATHER

Herman Wichmann

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Mo.

12. MAIDEN NAME OF MOTHER

Ida Steine

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Mo.

14. INFORMANT

(Address)

Pearl Wichmann

3529 So. Jefferson Ave

15. FILED

19

May 11 1929

REGISTRAR

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

July 13 - 1929.

17.

I HEREBY CERTIFY, That I attended deceased from *March 7*, 1929 to *July 13*, 1929 that I last saw him alive on *July 13*, 1929, and that death occurred, on the date stated above, at *8:25 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asthma Cardiac Chronic 131 950.

(duration) yrs. *5* mos. ds.

CONTRIBUTORY (SECONDARY)

Interstitial Nephritis

Chronic

(duration) yrs. *5* 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?

clinical findings

(Signed) *C. E. Moller* M. D.

7/13, 1929. (Address) *3537 S. Jefferson 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

DATE OF BURIAL

Concordia Cem.

7-15 1929.

20. UNDERTAKER

ADDRESS

Zegonker Bros. 2623 Cherokee 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.

1-2-213

