

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

Do not use this space.

26516

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis Mo* (No. *3619 Lee Ave.*)
 St. _____ Ward _____

File No.
 Registered No. **7782**
 St. _____ Ward _____

2. FULL NAME

Berta Bechtel
 (a) Residence. No. *3619 Lee* 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>March 18 - 1870</i>		
7. AGE	YEARS	MONTHS
	<i>59</i>	<i>4</i>
		<i>8</i>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <i>House Wife</i> 38 <i>127A</i>		
(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) *St. Louis Mo.*

10. NAME OF FATHER *Wm. H. Bechtel*

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

12. MAIDEN NAME OF MOTHER *Elizabeth Herbold*

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

14. INFORMANT *Wm. H. Bechtel*
 (Address) *2925 Union Blvd.*

15. FILED *27 1929* REGISTRAR *Max C. Stankov*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 26th 1929*
 17. I HEREBY CERTIFY, That I attended deceased from *July 13*, 19*29*, to *July 26*, 19*29*, that I last saw h. *alive* on *July 26*, 19*29*, and that death occurred, on the date stated above, at *9:40 A.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Empyema Gall bladder - (ruptured gall bladder)
 (duration) yrs. mos. *3* ds.
 CONTRIBUTORY (SECONDARY) *malarial fever*
 (duration) yrs. mos. *15* 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) *Theo. W. Conzelmann*, M. D.
7/26. 1929 (Address) *5043 Vermont 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. Cister Cem* DATE OF BURIAL *July 29 1928*

20. UNDERTAKER *Shirley Personal Int. 4355 Washington* ADDRESS

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.

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