

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

Do not use this space.

26670 E

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1903**
 City: **St. Louis** (No. **4326**, **Alaska**) St. Ward

File No.
 Registered No. **7980** St. Ward

2. FULL NAME

(a) Residence. No. **4326**, **Alaska** St., **18** 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

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 14 - 1862**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 7 16

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. **Housewife**
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **New Palestine**
 (STATE OR COUNTRY) **Ills**

10. NAME OF FATHER **Geo. Diskey**

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

12. MAIDEN NAME OF MOTHER **Harieth Young**

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

14. INFORMANT **Joseph Bauer**
 (Address) **4326 Alaska**

15. FILED **1929** **May C Bankoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 30 1929**

17. I HEREBY CERTIFY, That I attended deceased from **March 21 1929** to **July 30 1929** that I last saw her alive on **July 30 1929** and that death occurred, on the date stated above, at **3:50 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
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97A Aortic and Mitral Regurgitation
 (duration) yrs. mos. ds.
Chronic Interstitial Nephritis
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **1219 W**
 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) **D. B. W. Kippel** M. D.
July 31, 1929 (Address) **3772 1/2 Broadway**

*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 **New St Marcus** DATE OF BURIAL **Aug 2 1929**

20. UNDERTAKER **Wacker-Helders** ADDRESS **2331 S Broadway**

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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