

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

Do not use this space.

28957

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 3333) Michigan St. _____ Ward _____

File No. _____
 Registered No. 8063
 St. _____ Ward _____

2. FULL NAME

(a) Residence No. 3333 Michigan St. 16 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the words) <u>widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Phillip Heimberger</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 1 1857</u>				
7. AGE	YEARS <u>71</u>	MONTHS <u>11</u>	DAYS <u>0</u>	If LESS than 1 day, _____ hrs. or _____ min.

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER John Luerberger
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Regina Kufeling
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY) _____

14. INFORMANT Harry Heimberger
 (Address) 4624 Heidelberg Ave.

15. FILED 19 Max C. Stark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 1, 1929
 I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to Aug. 1, 1929 that I last saw her alive on Aug. 1, 1929 and that death occurred, on the date stated above, at 7:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis
Cerebra Hemorrhage
 (duration) 2 yrs. 0 mos. 0 ds.
 CONTRIBUTORY (SECONDARY) Cerebra Hemorrhage
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 (NOT AT PLACE OF DEATH)
 (DID AN OPERATION PRECEDE DEATH) No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Physical Findings
 (Signed) Joseph Bacelar M.D.
8/2 1929 (Address) 4602 Gravois

*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 Lakewood Park
 DATE OF BURIAL 8-3 1929

20. UNDERTAKER Witt Bros & Co 2929 S. Jeff Ave.
 ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS AN 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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