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

Do not use this space.

29215

**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. [illegible]

City St Louis (No. City Hospital St. ..... Ward)

File No. 8349

Registered No. .....

**2. FULL NAME** Mae Kuffer

(a) Residence. No. 1702 & 17 St., 23 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 31 - 1895

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 33 | 9 | 12 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(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)

PARENTS

10. NAME OF FATHER Joseph Kuffer

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

12. MAIDEN NAME OF MOTHER Mary Rajck

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

14. INFORMANT Hospital Information
(Address) City Hospital

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug 12, 1929 that I last saw h. alive on Aug 12, 1929 and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Alcoholic Cirrhosis of Liver
Chronic Alcoholism C
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Delirium Tremens
(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? Clinical

(Signed) Carl H. Hotz, M. D.
8/13, 1929 (Address) City Hospital

*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 |
|---|---|
| St Peter & Paul | August 15 1929 |
| **20. UNDERTAKER** | **ADDRESS** |
| Wm C Moydell | 1926 Allen Ave |

Kuffer.

JUL 3 1940