

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

Do not use this space.

32355

**1. PLACE OF DEATH**

County St. Louis Registration District No. 701  
 Township St. Louis Primary Registration District No. 1003  
 City St. Louis (No. St. Johns Hospital)

File No. ....  
 Registered No. 9418  
 St. .... Ward)

**2. FULL NAME** Betty Jane Kussmann

(a) Residence. No. 4209<sup>a</sup> Junata 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 word) <u>Infant</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 7, 1929

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>0</u>	<u>14</u>	

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

10. NAME OF FATHER Oliner Kussmann

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

12. MAIDEN NAME OF MOTHER Isabella Thomas

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

14. INFORMANT Oliner Kussmann  
 (Address) 4209<sup>a</sup> Junata St.

15. FILED 19 W. C. Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Sept 21, 1929 that I last saw h. or alive on Sept 21, 1929, and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Prematurity  
159

CONTRIBUTORY (SECONDARY) 1610  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) A. H. Root, M. D.  
 , 19 (Address) 330 Metropolitan Bldg.

\*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 <u>Memorial Park</u>	DATE OF BURIAL <u>9-23</u> 19 <u>29</u>
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20. UNDERTAKER <u>Gregg Hausw. Under</u>	ADDRESS <u>4228 S. Kingshigh way</u>
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