

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

Do not use this space.

32614

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis* No. *City Sanitarium* St. Ward)

File No.....
 Registered No. **9736**
 St. Ward)

2. FULL NAME *Mary Kahlmeyer*

(a) Residence. No. *14443 Seward* St., *18* 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

SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widowed</i>
----------------------	----------------------------------	--

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 16, 1883*

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, hrs. or min.
	<i>46</i>	<i>7</i>	<i>14</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Factory Worker*
 (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 *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT (Address) *Nenny Schlexer 5457 Measha St.*

15. FILED *2 1929* *Max C. Starkloff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

Found dead
 16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 30, 1929*
 17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... *6:55 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Strangulation due to hanging by cord
 (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) *Suicide*
 (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *John Murphy, M.D.*
10/1, 1929. (Address) *Deputy Coroner*
 *State the DISEASE CAUSING DEATH, omit 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 <i>St. Peter Paul Cemetery</i>	DATE OF BURIAL <i>10-3 1929</i>
20. UNDERTAKER <i>regshauser U.E. Manchester</i>	ADDRESS <i>710 v</i>

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.

59
1
10
1

