

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

Do not use this space.

35520

File No. 10270
Registered No. 10270
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. 701
Township..... Primary Registration District No. 1003
City..... (No. 2210 So. 18th St.)

2. FULL NAME

Theresa Hamhoff
(a) Residence. No. 2210 So. 18th St. s. 23 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 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 Ired Hamhoff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 18-1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 14 - -

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 Herself

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) MO
10. NAME OF FATHER (?) Shurf
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No longer
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14.

INFORMANT Ired Shurf
(Address) 2210 So. 18th St

FILED OCT 20 1929 REGISTRAR Wm C Stenberg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 18, 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 520 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
950 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 90B (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. H. [Signature] M.D.
119. 1829 (Address) Deputy Coroner

*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's cemetery Oct 21, 1929

20. UNDERTAKER ADDRESS Goodhart & Goodhart 2228 St Louis Ave

WRITE PLAINLY, WITH FADING INK---THIS IS A 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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