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

Do not use this space.

35612

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 10383

Township ..... Primary Registration District No. 2100 Registered No. .....

City St Louis (No. Cass City City Hosp. St. ..... Ward)

2. FULL NAME Mary A. Lee

(a) Residence. No. 1906 S. 7th. 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 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	widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 2. 1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	68.	1	19	

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

9. BIRTHPLACE (CITY OR TOWN) Bohemia
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER William Heyderchal

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

12. MAIDEN NAME OF MOTHER Mary Ott

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

14. INFORMANT Julia Kunes
(Address) 5601. S. Broadway

15. FILED OCT 23 1929 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 21 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 8 55 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries
210 G Crushed Chest
210 M
Struck & Run over
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) by Auto
St Louis Mo
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Accident
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner, M.D.
10/23 1929 (Address) Dep. Coron

*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
New St Marcus	Oct 24 1929

20. UNDERTAKER	ADDRESS
Thos Kutis	2986 Gravois

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.