

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

Do not use this space.

35619

1. PLACE OF DEATH

County St. Louis

Registration District No. 791

Township

Primary Registration District No. 1003

City St. Louis, Mo.

(No. Mo. Bapt. Hosp.)

File No. 10393

Registered No. 10393

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2732 Pastern Ave. St. Louis, Mo. (Usual place of abode) Mo. Baptist Hosp. 6th Min. Ward. 12 Overland Mo. (if nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6th Min. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX f 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-20-29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 6th Min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Doctor -
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Mr. Herbert Heicht

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) 2732 Pastern Overland Mo.

12. MAIDEN NAME OF MOTHER Anna Dorothy Godbey

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

14. INFORMANT H. K. Leicht (Address) Overland Mo.

15. FILED 23 1929 Max C. Stinner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 20 1929

17. HEREBY CERTIFY, That I attended deceased from Birth 19____ to _____ 19____ that I last saw her alive on Oct. 20 7:50 P.M. 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature foetus.
6 months gestation.
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) Paul R. White M. D.

, 19 (Address) 2573 Woodson - Overland

*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

10-24-1929

20. UNDERTAKER ADDRESS

E. Shannon, 1426 Carroll

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.

