

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

Do not use this space.

35846

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No. *me. Baptist Cemetery*)

Registration District No. *791*
Primary Registration District No. *1003*

File No.
Registered No. *10649* ..
St. Ward)

2. FULL NAME *Nora Kahnhoff*

(a) Residence. No. *4121^a St. 22nd* St., *9* 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*) *single*

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *10/29/1929*

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer). *None*
(c) Name of employer

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

PARENTS	10. NAME OF FATHER <i>George J. Kahnhoff</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <i>St. Louis</i> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <i>Nora Rodgers</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <i>St. Louis</i> (STATE OR COUNTRY)

14. INFORMANT *George J. Kahnhoff*
(Address) *4121^a St. 22nd*

15. FILED *OCT 30 1929* *Max C. Barlett* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/30/1929*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 29*, 19*29*, to *Oct 30*, 19*29*, that I last saw h. *ev* alive on *Oct 30th*, 19*29*, and that death occurred, on the date stated above, at *6 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ulcerative Spinal Meningitis leaving 2/3 spinal fluid -
(duration) yrs. mos. *1* ds.
CONTRIBUTORY *fracture, dislocation of left hip - at birth*
(duration) yrs. mos. *1* ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. *1591*

19. DID AN OPERATION PRECEDE DEATH DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *J. H. [Signature]* M. D.
Oct 30th 1929 (Address) *7500 W. Audubon*

*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 *Calvary Cemetery* DATE OF BURIAL *10/31/1929*

20. UNDERTAKER *Probst and Co.* ADDRESS *3710 9th St.*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

