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

Do not use this space.

39192

1. PLACE OF DEATH

County ..... Registration District No. 1003 791 File No. 11676

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

City St Louis Mo. (No. 4019 Magnolia Pl. St. ..... Ward)

2. FULL NAME Statherine Farrell

(a) Residence. No. 4019 Magnolia Pl. St., 17 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	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 14 - 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	75	6	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

10

PARENTS

10. NAME OF FATHER S. Stroll.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Dont know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany.
(STATE OR COUNTRY)

14. INFORMANT Mrs Hans Wagenfuehr
(Address) 4019 Magnolia Pl.

15. FILED Nov 30 1929 Max C Tomkins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 27th 1929

17. I HEREBY CERTIFY, That I attended deceased from 11/23, 1929, to 11/27, 1929 that I last saw her alive on 11/26, 1929 and that death occurred, on the date stated above, at 6:35 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

1010

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH ✓

DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. W. Ferman, M. D.

11/28, 1929 (Address) 2924 S Grand Pl

*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
Calvary.	Nov. 30 1929
20. UNDERTAKER	ADDRESS 1417
Hy Leidner Und Co.	N. Market 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

2924 S. [illegible]