

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

Do not use this space.

42008

1. PLACE OF DEATH
 County St. Louis 6 Registration District No. 1123
 Township Wardside Primary Registration District No. 0248 E
 City St. Louis (No. 9423 So. Broadway) St. _____ Ward _____

2. FULL NAME Amelia Hagemester
 (a) Residence. No. 9423 S. Broadway St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 | 5 | 7 | _____

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) At Home
 (c) Name of employer _____

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

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
 (STATE OR COUNTRY)

14. INFORMANT Mainie Gardyne
 (Address) 9423 S. Broadway

15. FILED Dec 29 1929 L. C. Obrook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 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 _____ 9 am. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
926
97
 _____ (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
 _____ (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Microbiological
 (Signed) John Donnell, M. D.
 , 19____ (Address) Former of St. Louis Society

*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 Marthasville Mo DATE OF BURIAL Dec 28 1929

20. UNDERTAKER Hendler Hud Co ADDRESS 7519 Mich Co

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

JAN 24 1930
 96

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.

