

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

1003

Township.....

Primary Registration District No.

City **St. Louis, Mo.** (No. **Lutheran Hospital**)

File No. **42760**

Registered No. **12548**

St. Ward)

2. FULL NAME Caroline Graber

(a) Residence. No. **1955a Utah** St. **24** Ward.

Length of residence in city or town where death occurred yrs. mos. ds.

(If nonresident, give city or town and State)

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 **Widow** (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Herman H. Graber**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **February 24, 1850**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 9 28

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

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

PARENTS
10. NAME OF FATHER **Frank Landherr**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
12. MAIDEN NAME OF MOTHER **Unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT **Helena Sigg** (Address) **1955a Utah Street**

15. FILED **DEC 26 1929** REGISTRAR **[Signature]**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **December 22, 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Dec. 5th**, 19**29**, to **Dec. 22**, 19**29** that I last saw **her** alive on **Dec. 22**, 19**29**, and that death occurred, on the date stated above, at **11:30** A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterial Sclerosis

(duration) **several** yrs. mos. ds.
CONTRIBUTORY **mental deterioration** (SECONDARY) (duration) **1** yrs. **1** 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) **Wm. R. [Signature]**, M. D.
Dec 23, 1929 (Address) **2946 Gravois Ave.**

*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 **SS. Peter & Paul** DATE OF BURIAL **12/26/ 19 29**

20. UNDERTAKER **Wacker-Heldner** ADDRESS **2531 S. Brdwy.**

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

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.

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