

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

Do not use this space.

2673

1. PLACE OF DEATH

County

Registration District No. **791**

File No.

Township

Primary Registration District No. **1003**

Registered No. **101**

City **St James Mo** (No. **8121**) **Trinity Ave**

St. Ward)

2. FULL NAME

(a) Residence. No. **8121** **Trinity Ave**
(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) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb 20 1853**

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	76	10	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House work**
(b) General nature of industry, business, or establishment in which employed (or employer) **At Home**
(c) Name of employer

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

10. NAME OF FATHER **Ben Frank**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Hett Krieger**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

14. INFORMANT **R. Engler**
(Address) **8121 Trinity Ave**

15. FILED **JAN - 8 1930**
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 2 - 1930**

17. I HEREBY CERTIFY That I attended deceased from **Dec 15**, 19 **27**, to **Jan 2**, 19 **30** that I last saw him alive on **Jan 1**, 19 **30**, and that death occurred, on the date stated above, at **11:00** a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: **10:30 A. 131 92A Mitral Insufficiency**

Chronic Interstitial Nephritis (duration) **1** yrs. **10** mos. **10** ds. CONTRIBUTORY (SECONDARY)

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

DID AN OPERATION PRECEDE DEATH? **No** DATE OF WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **R. H. Peters** (Signed) **M. D.**

June 2, 1929 (Address) **601 Missouri Bldg**

*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 **St James Cemetery** DATE OF BURIAL **Jan 6/30**

20. UMBERTAKER **Genevieve Kuhl** ADDRESS **7819 Michigan**

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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