

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *Louis*

Registration District No. *791*
Primary Registration District No. *1005*

File No. *2696*
Registered No. *126*
St. _____ Ward _____

2. FULL NAME

Anna Kischoff
(a) Residence, No. *24 Widener's Place* St., *12th* 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*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 28-1867*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
62 9 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Maid*
(b) General nature of industry, business, or establishment in which employed (or employer) *Laundromat*
(c) Name of employer *Mr. H. G. Hafner*

9. BIRTHPLACE (CITY OR TOWN) *Black Jack* (STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Mr. known Kischoff*

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

12. MAIDEN NAME OF MOTHER *Mr. known*

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

14. INFORMANT *H. G. Hafner* (Address) *24 Widener's Pl*

15. FILED *JAN 5 1930* *Ray J. Barker* REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 4 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Sept*, 1926, to *Jan 4*, 1930 that I last saw him alive on *Jan 3*, 1930, and that death occurred, on the date stated above, at *7 a*. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia - rt lower lobe
108
92A
_____ (duration) _____ yrs. _____ mos. *4* ds.

CONTRIBUTORY (SECONDARY) *Chronic valvular disease heart* (duration) *10* yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) *W. Fisher*, M. D.

Jan 4 1930 (Address) *3720 Washway*

*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

Black Jack Cem *Jan 6 1930*

20. UNDERTAKER ADDRESS

W. R. L. Co *2707 Grand*

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 126
 City St. Louis (No. _____ St. _____ Ward)

2. FULL NAME

Anna Nieschog
 (a) Residence. No. _____ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT _____
 (Address)

15. FILED _____
 19__

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 -1920

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prudentia, rt. Lower lobe
Lobar
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY chronic salivular disease
(SECONDARY)
heart (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. 1010

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 _____, 19____ (Address)

*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

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED.

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