

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

Do not use this space.

6592

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **1327**)

Montclair Ave

File No.

Registered No. **1408**

St. Ward

2. FULL NAME

(a) Residence. No. **1327 Montclair** St., **6** 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)

Married

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

Charles Stahl

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

Sept. 3, 1875

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

54

5

6

8. OCCUPATION OF DECEASED

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

Home

(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)

Ill

10. NAME OF FATHER

John Lee

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

England

12. MAIDEN NAME OF MOTHER

Emma Jeffe

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

England

14. INFORMANT

(Address)

**Charles Stahl
1327 Montclair**

15. FILED

FILED

May 1931

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Feb. 9, 1930

17.

I HEREBY CERTIFY, That I attended deceased from **Sept. 1925** to **Feb. 9, 1930** that I last saw her alive on **Feb. 8, 1930** and that death occurred, on the date stated above, at **10** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Lympho-sarcoma of the
472 mediastinum**

152B (duration) **5** yrs - mos - ds.
CONTRIBUTORY **Decubitus abscess of**
(SECONDARY) **left foot** (duration) - yrs - mos - ds. **8**

18. WHERE WAS DISEASE CONTRACTED

449 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Paul Lowenstein** M. D.

Feb. 10, 1930 (Address) **University Club 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

DATE OF BURIAL

Stenton, Ill

Feb. 11, 1930

20. UNDERTAKER

ADDRESS

Drehmann Naval 1905 Union

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.

235

87

RECORD

University Club Bldg
D off 4282