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

Do not use this space.

File No. 6873

Registered No. 1711

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City St Louis (No. 4655 Idaho Ave St. ..... Ward)

2. FULL NAME Katherine Metter

(a) Residence. No. 4655 Idaho Ave St., 15 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	76	2	5	

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) St Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER George Danner

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

12. MAIDEN NAME OF MOTHER Sophia Beckloff

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

14. INFORMANT George Roth
(Address) 4655 Idaho Ave

15. FILED ....., 19.... Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 ....., 19.30, to Feb 17 ....., 19.30 that I last saw him alive on Feb 17, 1930 and that death occurred, on the date stated above, at 11:10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial
Nephritis Advanced
131 Hypertension
132B ..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) 8 yrs. ..... 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 Trial
(Signed) W. Canning M. D.
4/17, 19 30 (Address) 2844 Wy

*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
SS Peter Paul	Feb 19 1930
20. UNDERTAKER	**ADDRESS**
Wacker-Helderle	2331 S Broadway

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.

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

10 / 235