

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

Do not use this space.

6907

1. PLACE OF DEATH

County.....
Township.....
City..... (No. *709 - Marion*)

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *1758*
St. Ward)

2. FULL NAME

(a) Residence. No. *709 - Marion* St., *(23)* 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) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 8 - 1856*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 10 10

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *at 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) *Illinois*

10. NAME OF FATHER *John Mordlock*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs Emma Hunt* (Address) *709 - Marion St*

15. FILED *19* *May 133 - May C. Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 18 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 12*, 19*30*, to *Feb 17*, 19*30*, that I last saw him alive on *Feb 17*, 19*30*, and that death occurred, on the date stated above, at *5:10 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92C *Ch. Myocarditis*
107A *Acute pneumonia*
16a (duration) *1 - 5 days* yrs. *2* mos. *21* ds.

CONTRIBUTORY (SECONDARY) *Smoking* (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Physical signs*
(Signed) *Henry H. Hays* M. D.

Feb 18 1930 (Address) *514 Westinghouse 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 *S S Peter Paul* DATE OF BURIAL *Feb 20 1930*

20. UNDERTAKER *Wacker-Heldsrlc* ADDRESS *2331 - S Blum*

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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H. P. Thym