

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

Do not use this space.

7287

1. PLACE OF DEATH

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

Registration District No. *791*
Primary Registration District No. *1008*
(No. *6700* *Michigan*)

File No.....
Registered No. *2176*
St. Ward)

2. FULL NAME

Emilie Leinweber

(a) Residence. No. *6700 Michigan* St., *1* Ward.

(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*) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 5, 1846*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
83 8 23

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) *Germany*

10. NAME OF FATHER *Paul Herold*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs Rosa Wunderski*
(Address) *6700 Michigan Ave.*

15. FILED *1930* REGISTRAR *Wm C Wunderski*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb. 28 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 27 1930* to *Feb 28 1930*, that I last saw her alive on *Feb 28 1930*, and that death occurred, on the date stated above, at *9:00 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Bronchitis & Sm. Myocarditis non Tubercular

CONTRIBUTORY (SECONDARY) *several Infinites of old*

(duration) yrs. mos. ds. *10 yrs 10 mo*

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 only*

(Signed) *Alfred Oppenheimer, M. D.*

3/1 1930 (Address) *6607 Va. Ave*

*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

Missouri Crematory 3/3 1930

20. UNDERTAKER ADDRESS

C. Hoffmeister & Co 7814 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 ONE WORD

10 2330

700. copy of the same