

APR 30 1930

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

Do not use this space.

10059

1. PLACE OF DEATH

County *St. Louis*

Registration District No. *784*

Township *St. Ferdinand*

Primary Registration District No. *6030*

City *Jennings*

(No. *2426 Mary Ave*)

File No.

Registered No.

St. Ward)

2. FULL NAME

Anna Bremer

(a) Residence. No. *2426 Mary* 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. 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

Robert Bremer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 9, 1860*

7. AGE

YEARS MONTHS DAYS
70 1 1

If LESS than 1 day, hrs. or min.

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) *St Louis*
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Wm Brockmeyer*

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

12. MAIDEN NAME OF MOTHER *Louise Meyer*

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

14. INFORMANT *John B. Schuch*
(Address) *2426 Mary Ave*

15. FILED *3/16/30* *O. N. Schutte* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar. 10* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *Mar. 27* 19 *30* to *Mar. 10* 19 *30* that I last saw h. e. t. alive on *Mar. 6* 19 *30* and that death occurred, on the date stated above, at *8:30 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of the stomach

4 1/2 (duration) *3* yrs. mos. ds.

CONTRIBUTORY *none*
(SECONDARY) (duration) 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) *J. A. Van der Stoeper* M. D.

3/10, 1930 (Address) *8313 Halls Ferry Rd*

*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 *St. John's Cemetery* DATE OF BURIAL *Mar 13 19 30*

20. UNDERTAKER *A. Kron L. W.* ADDRESS *2707 N. Grand*

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.

WHITE PEARL ST. WITH UNWRAPPING INK—THIS IS FOR PERMANENT RECORD

