

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

Do not use this space.

10890

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *San Francisco*

Registration District No. **791**  
**1003**  
Primary Registration District No. *San Francisco*  
(No. *4844*)

File No.....  
Registered No. **2917**  
St..... Ward.....

**2. FULL NAME**

(a) Residence. No. *4844 San Francisco St.* **7** 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) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 10, 1954*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>85</i>	<i>11</i>	<i>11</i>	

**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) *Germany*  
(STATE OR COUNTRY)

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Ella Loober*  
(Address) *4844 San Francisco*

15. FILED *MAR 22 1930* *Max V. Starck*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** *March 21, 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 15, 1929*, to *Mar 21, 1930*, that I last saw her alive on *Mar 20, 1930*, and that death occurred, on the date stated above, at *7:30 a. m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Pneumonia Lobar*  
*100*  
*77*

(duration) *0* yrs. *0* mos. *6* ds.

CONTRIBUTORY (SECONDARY) *arteriosclerosis*

(duration) *6* yrs. *6* mos. *0* ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH *Home*

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *nope*  
(Signed) *LC R. Polking* M. D.

*Mar 22, 1930* (Address) *3126 M. Island*

\*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**

*Memorial Park Cem*

*Mar 24 1930*

**20. UNDERTAKER**

**ADDRESS**

*Trethmann / Haral*

*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.

WRITE FOR COPY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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31262 Groundy

930 A.M.