

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

Do not use this space.

11090

1. PLACE OF DEATH

County..... Registration District No. 791
 Townshp..... Primary Registration District No. 1003
 City St. Louis (No. City Hospital)

File No.....
 Registered No. 3124
 St..... Ward.....

2. FULL NAME

(a) Residence. No. 3949 Blair St. 261 Ward.....
 (Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 16 1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 6 21

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) Missouri

10. NAME OF FATHER August Brown

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

12. MAIDEN NAME OF MOTHER Julia Zigmund

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

14. INFORMANT (Address) Dr. Karan

15. FILED..... 19..... REGISTRAR W. C. Tolson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 27 1930

17. I HEREBY CERTIFY That I attended deceased from March 19 1930 to March 27 1930, that I last saw he alive on March 27 1930 and that death occurred, on the date stated above, at 3:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
Colloid Edema 93c
Paralysis Agitans 87E
Seribity (duration) yrs. mos. ds. 6 6 6

CONTRIBUTORY (SECONDARY) (duration) 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
 (Signed) Carl M. Hays M. D.

3 27 1930 (Address) City Hospital

*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 Driedens DATE OF BURIAL March 31 1930

20. UNDERTAKER Math Hermann & Son 2161 Park ADDRESS On

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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Margraff.