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

Do not use this space.

13996

1. PLACE OF DEATH

County ..... Registration District No. 791 1002 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 3304

City St. Louis (No. ISOLATION HOSPITAL St. 24th Ward)

2. FULL NAME Emma Bauser

(a) Residence. No. 520 Garden St., 13 Ward. Webster Groves Mo
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	widow

5A. [redacted], WIDOWED, OR [redacted] (OR) WIFE OF Julius Bauser

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
about	79			

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

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)

14. INFORMANT (Address) E. Sheridan ISOLATION HOSPITAL

15. FILED ..... 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-1 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-29, 1930 to 4-18, 1930 that I last saw her alive on 4-1, 1930 and that death occurred, on the date stated above, at 7:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
930
1525 (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cellulitis of both leg Cause
Unknown (duration) yrs. mos. 16 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) Bel Kirkbill, M. D.
4/1, 1930 (Address) ISOLATION 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	DATE OF BURIAL
Oak Hill Cemetery	4/3/30 19
20. UNDERTAKER	ADDRESS
Coghan Und. Co. 7146	Manchester

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.