

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

Do not use this space.

14381

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo (No. 6) City Sanitarium St. Ward)

File No.
 Registered No. 3725
 St. Ward)

2. FULL NAME

Josephine Klaidor
 (a) Residence, No. 4012 M^e Lee Ave., 13 Ward.

Length of residence in city or town where death occurred 20 yrs. + mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 21, 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 10 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
 (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)
Hamburg Pennsylvania

10. NAME OF FATHER Unknown

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 E. H. Coan
 (Address) City San. St. Louis Mo

15. FILED May 21 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 12 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 31, 1930, to April 12, 1930 that I last saw h. e. alive on April 12, 1930, and that death occurred, on the date stated above, at 1 p. m.

34 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute meningitis
 (duration) yrs. mos. 5 ds.
 CONTRIBUTORY Central spinal discs
 (SECONDARY) (duration) yrs. mos. 13 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH unknown

0 DID AN OPERATION PRECEDE DEATH? no DATE OF none
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical + lab
 (Signed) E. H. Coan, M. D.

4-12-1930 (Address) St. Louis Mo

*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 New. St. Marcus. DATE OF BURIAL 4-15 1930

20. UNDERTAKER Mr. Schumacher. ADDRESS 3013
Wormure

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.

