

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

Do not use this space.

14493

File No.
Registered No. **3839**
St. Ward)

1. PLACE OF DEATH

County Registration District No. **701**
Township Primary Registration District No. **7002**
City **St. Louis** (No. **City**)
Rose (No. **St. Louis**)

2. FULL NAME

(a) Residence No. **1127 N 12th** St. **75** Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **30** 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) Widowed	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 6 - 1899					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.	
	30	11	8		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work Housewife					
(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					
PARENTS	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 (Address) City of St. Louis					
15. FILED APR 19 1930 REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 14 1930**
17. I HEREBY CERTIFY That I attended deceased from **April 9 1930** to **April 14 1930** that I last saw him alive on **April 14 1930** and that death occurred, on the date stated above, at **9:22 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lobar Pneumonia
108 (Left Upper Lobe)
64 (duration) yrs. mos. **4** ds.
CONTRIBUTORY (SECONDARY) **Psychosis Type**
Undetermined (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH **127 No. 12 St**
DID AN OPERATION PRECEDE DEATH? **no** DATE OF **no**
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Ben Margulies**, M. D.
4/15 1930 (Address) **City of St. Louis**

*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 **Calvary** DATE OF BURIAL **April 17 1930**
20. UNDERTAKER **Bennick Sibaw** ADDRESS **4138 N 6th**

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.

Kindle

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