

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

Do not use this space.

14651

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo. (No. 2811 N. 14th St.) St. Ward (If nonresident, give city or town and State)

2. FULL NAME

Julia Kallzams
 (a) Residence, No. 2811 N. 14th St. St. 26 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 4 - 1864

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>66</u>	<u>0</u>	<u>0</u>	<u>15</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lignett & Meyer
 (b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Co
 (c) Name of employer Stricker

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Michigan

10. NAME OF FATHER

John Beach

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Georgia

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Georgia

14.

INFORMANT Miss Stites
 (Address) 2811 N. 14th St.

15.

FILED APR 22 1930 Max C. Hardy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 19 1930

17. No Physician in attendance
 I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 4:50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C

CONTRIBUTORY (SECONDARY)

90B

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) John P. Hickey M.D.

4/21 1930 (Address) Deputy Coroner

*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

St. John North Cemetery April 23 1930

20. UNDERTAKER Hy. Leidner Ltd. Co. ADDRESS 1417 N. Market St.

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.

