

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

701

Township.....

Primary Registration District No.....

1003

City.....

(No. 4770)

Green Ave

File No. **14727**  
Registered No. **4131**  
.....St. ....Ward)

**2. FULL NAME**

(a) Residence. No. 4770 of Green

St. 6

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)**

Widowed

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

George A Emmett

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

Jan 28, 1850

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, .....hrs. or .....min.

80

2

20

**B. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....

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)

Ohio

**10. NAME OF FATHER**

Henry Wehe

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ohio

**12. MAIDEN NAME OF MOTHER**

Mary Unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ohio

**14.**

INFORMANT.....

(Address)

Stachrine Tramer  
4770 Green Ave

**15.**

FILED.....

19.....

Mar 23 1935  
Max C. Stahl

REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

April 23 1930

**17.**

I HEREBY CERTIFY, That I attended deceased from Nov 5, 1928 to date, 1929, and that I last saw her alive on Jan 19, 1929, and that death occurred, on the date stated above, at 3:30 p. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Organic Heart 92A  
Lesion 95B  
Chronic Mitral Regurgitation  
(duration) 18 yrs. 8 mos. ds.

**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?

(Signed).....

J. C. Brooks, M. D.

, 19 (Address) Paul Brown Bldg

\*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 Peter Cemetery

April 26, 1930

**20. UNDERTAKER**

**ADDRESS**

Drehmann Haval

1905 Union

K. 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.

WHITE COPY WITH "UNEXPIRED INK"—THIS IS A PERMANENT RECORD

From 1 to 100