

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.

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

15348

**1. PLACE OF DEATH**

County Buchanan

Registration District No. 85

Township \_\_\_\_\_

Primary Registration District No. 1001

City St. Joseph

(No. 2621 Seneca Street.)

File No. \_\_\_\_\_

Registered No. 567

St. \_\_\_\_\_

Ward \_\_\_\_\_

**2. FULL NAME**

Elizabeth Marie Czernicke.

(a) Residence. No. 2621 Seneca Street.

St. \_\_\_\_\_

Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 9 mos. 6 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**

Bernard J. Czernicke.

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** July 31, 1878.

**7. AGE**

YEARS 51

MONTHS 9

DAYS 6

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

**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)** St. Joseph,

(STATE OR COUNTRY)

Missouri.

**10. NAME OF FATHER** Albert Pasternak.

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

(STATE OR COUNTRY)

Germany.

**12. MAIDEN NAME OF MOTHER** Magdalen Meyer.

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

(STATE OR COUNTRY)

Germany.

**14. INFORMANT** Bernard J. Czernicke.

(Address) 2621 Seneca Street.

**15. FILED** 5/9, 19. 30 John E. [Signature] REGISTERAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** May 7, 19 30

**17. I HEREBY CERTIFY, That I attended deceased from** Aug. 1, 19. 30, to May 7, 19. 30

that I last saw her alive on May 7, 19. 30, and that death occurred, on the date stated above, at 11:43 Pm.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

92A Alveolar Heart Disease.

93C Chronic Myocarditis.

11B General Edemata

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Pulmonary Edema

(SECONDARY)

(duration) \_\_\_\_\_ yrs. mos. 4 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) [Signature], M. D.

May 8 . 19 30 (Address) 216 Phys + Surg. 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**

Mount Olivet Cemetery.

**DATE OF BURIAL**

May 10 19 30

**20. UNDERTAKER**

H.C. Sidenfaden

**ADDRESS**

1802 Union St.

