

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

Do not use this space.

18021

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City **St. Louis, Mo.** (No. **1903a**, **Miami Street**)

File No. ....  
Registered No. **5175**  
St. .... Ward)

**2. FULL NAME** **Anna Langknecht**

(a) Residence. No. **1903a Miami Street** St. **24** Ward. ....  
(Usual place of abode) (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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 25th, 1930**

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

17. I HEREBY CERTIFY, That I attended deceased from **June**, 19**27**, to **May 25**, 19**30**, that I last saw him alive on **May 25**, 19**30**, and that death occurred, on the date stated above, at **7:40 a** m.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb. 23, 1885**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**45 3 2**

**Cerebral Apoplexy**  
**131**  
**924**  
**07**

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

CONTRIBUTORY **Arteriosclerosis (Chronic Bright's Disease)** (SECONDARY) (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) **Belleville** (STATE OR COUNTRY) **Illinois**

18. WHERE WAS DISEASE CONTRACTED **129 W** IF NOT AT PLACE OF DEATH.

10. NAME OF FATHER **Jacob Klein**

DID AN OPERATION PRECEDE DEATH? **No.** DATE OF

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

WAS THERE AN AUTOPSY? **No.**

12. MAIDEN NAME OF MOTHER **Unknown**

WHAT TEST CONFIRMED DIAGNOSIS? **Examination**  
(Signed) **Alvando Gillman D.C.M.D.**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

**May 25, 1930** (Address) **3423 E. Jefferson Ave**

14. INFORMANT **Denny Langknecht** (Address) **1903a Miami St.**

\*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.

15. FILED **MAY 27 1930** REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Sunset Burial Park** DATE OF BURIAL **May 28, 19 30**

20. UNDERTAKER **Wacker Heland** ADDRESS **2331 S. Brdwy.**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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