

**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. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 2831, S. 18 St.) St. _____ Ward _____

21017 ~~24115~~
 File No. _____
 Registered No. 5848

2. FULL NAME Gertrude Helfrich

(a) Residence No. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Jacob Helfrich

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 7-1855

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>75</u>	<u>2</u>	<u>9</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
 (b) General nature of industry, business, or establishment in which employed (or employer) Housework
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER John Von Stern

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

12. MAIDEN NAME OF MOTHER Johanna Canabon

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

14.

INFORMANT Rosa Kiehlberg
 (Address) 5243^{1/2} Lavoisier Ave

15.

FILED 17 1935 W. C. Howard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1930 to June 16, 1930 that I last saw h... or alive on June 15, 1930, and that death occurred, on the date stated above, at 12:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93c
97

(duration) yrs. mos. da. General Arteriosclerosis
 CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

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? Clinical
 (Signed) George E. Copp, M. D.

, 19 (Address) 372 So Broadway

*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 - Paul Cemetery June 19 1930

20. UNDERTAKER

ADDRESS

J. H. Fisher 2630 Travis Ave.

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS PERMANENT RECORD

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Linnæus