

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

Do not use this space.

~~21191~~
~~21032~~
File No. _____
Registered No. **5866.**

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City, St. Louis (No. 4466 Wholozan Ave)

File No. _____
Registered No. **5866.**
St. _____ Ward _____

2. FULL NAME

Irene Klatt
(a) Residence. No. 4466 Wholozan Ave St. 16 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Herman Klatt</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 7, 1894</u>		
7. AGE	YEARS <u>35</u>	MONTHS <u>6</u>
	DAY <u>8</u>	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>St. Louis Mo.</u> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <u>John Nagensieker</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>St. Louis Mo.</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Ida Schallenburg</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Franklin Co. Mo.</u> (STATE OR COUNTRY)	
14. INFORMANT <u>John Nagensieker</u> (Address) <u>4466 Wholozan Ave</u>		
15. FILED <u>Jan 17 1930</u> REGISTRAR <u>Mar C. Steyer</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-15 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-1 1920 to 6-15 1930
that I last saw her alive on 6-14 8:30 P.M. 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
53c tumor of Brain
Malignant

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 49
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) I. M. Senny M. D.
, 19 (Address) Creve Coeur Mo

*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 <u>New St. Marcus Cem</u>	DATE OF BURIAL <u>6-18 1930</u>
20. UNDERTAKER <u>Fuegchausen Und Co. Springfield</u>	ADDRESS <u>4278</u>

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.

