

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

Do not use this space.

25069

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. Sanitarium) St. _____ Ward _____

2. FULL NAME

Antonia Heil
 (a) Residence, No. 1938 Arsenal St. 13 Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 56 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) Single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 56

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dressmaker
 (b) General nature of industry, business, or establishment in which employed (or employer) Unknown
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Dr. Muller
 (Address) 5400 Arsenal

15. FILED 21 1930 W. C. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-20 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1911, to 7-20, 1930, that I last saw her alive on 7-20 1930, and that death occurred, on the date stated above, at 5:45 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
 (duration) 19 yrs. 5 mos. ds.

CONTRIBUTORY (SECONDARY) Mania Depressive
Psychosis (duration) 19 yrs. 5 mos. ds.

18. WHERE WAS DISEASE CONTRACTED 93C
 IF NOT AT PLACE OF DEATH BA

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
 (Signed) Dr. Muller, M. D.

7-20 1930 (Address) 5400 Arsenal

*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 S.S. Peter & Paul DATE OF BURIAL July 22, 1930

20. UNDERTAKER Stood & Carroll ADDRESS 4600
Kath Budge

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

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.

