

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... (No.....)

Registration District No. **791**
Primary Registration District No. **1003**
Central Hosp

File No. **25302**
Registered No. **7534**
St..... Ward.....

2. FULL NAME

Margaret Uhlenhof
(a) Residence, No. **6709 Karner Ave.** **4** Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **18** yrs. mos. ds. How long in U.S., if of foreign birth? **18** yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Wife of Ernst Herman Uhlenhof*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 29, 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 *9* *27*

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) *Germany*
(STATE OR COUNTRY) *to Heiland*

10. NAME OF FATHER *Heiland*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs. B. M. Martinez*
(Address) *6709 Karner Ave.*

15. FILED *JUL 28 1930*
REGISTRAR *W. C. Stanley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 26 1930*

17. I HEREBY CERTIFY, That I attended deceased from *July 23* 1930 to *July 26* 1930 that I last saw her alive on *July 26* 1930, and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chokepneumonia
127B
59 (duration) yrs. mos. ds.
CONTRIBUTORY *Diabetic mellitus*
(SECONDARY) (duration) *1* yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *July 24/30*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Lab*
(Signed) *John D. Gray, M.D.*
July 26, 1930 (Address) *Metropolitan 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 *Memorial Park Cem.* DATE OF BURIAL *July 30 1930*

20. UNDERTAKER *Sharkey* ADDRESS *4355 Washington*

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.

