

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

Do not use this space.

28018

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City**)

File No.

Registered No. **7847**

St. Ward)

2. FULL NAME

(a) Residence. No. **214** **Penrose** St., **7** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **7** yrs. **7** mos. **7** 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** **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 7 - 1853**

7. AGE YEARS **76** MONTHS **10** DAYS **28** IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Austria**

10. NAME OF FATHER **Carl Hochmeister**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Edmund**
(Address) **City St. Louis**

15. FILED **ALG - 6 1930** **Edmund** REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **August 4 1930**

I HEREBY CERTIFY, That I attended deceased from **July 29** 19**30** to **Aug 4 30** that I last saw him alive on **Aug 4 1930** and that death occurred, on the date stated above, at **7:50 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
9 10 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **9 10** (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? **No** DATE OF **9 10**
WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical**
(Signed) **Raymond J. Jacobs** M.D.
8/5 1930 (Address) **City St. Louis**

*State the DISEASE CAUSING DEATH, or 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 **Calvary Cem** **DATE OF BURIAL** **August 19 30**

20. UNDERTAKER **Edmund Koch** **ADDRESS** **3576 N. 14 St**

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.

Handisch