

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

Do not use this space.
28161

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **10083**

City **St. Louis Mo.** No. **5451 Partridge**

File No.

Registered No. **8001**

St. Ward)

2. FULL NAME

Pauline Graf

(a) Residence. No. **5451 Partridge** St. **7** Ward.

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

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

Sept. 10 - 1852

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
77	10	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House Wife**

(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) **Germany**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Marie Henrichsofer**
(Address) **5451 Partridge Ave.**

15. FILED **AUG 11 1930**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug. 9 - 1930**

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 9, 1930, that I last saw her alive on Aug 9, 1930, and that death occurred, on the date stated above at 12:15 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Regurgitation
92 A
191 (duration) yrs. mos. / da.

CONTRIBUTORY (SECONDARY) **Insulation**
(duration) yrs. mos. / da.

18. WHERE WAS DISEASE CONTRACTED **1914**
IF NOT AT PLACE OF DEATH

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

WHAT TEST CONFIRMED DIAGNOSIS? **Neural Symptoms**
(Signed) **P. E. Alexander**, M. D.
8/10, 1930 (Address) **5736 N. Florissant**

*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 **St. Matthews Cem.** **8-11-1930**
DATE OF BURIAL

20. UNDERTAKER **Ziegenheim Bros. 2643 Cherokee St.**
ADDRESS

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 A PERMANENT RECORD

