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

Do not use this space.

28190

File No.

Registered No. 8031

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 Elizabeth Stahl

(a) Residence. No. 3914 Minnesota Ave., 13 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 8 - 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	76	7	1	

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) Unknown
(STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT John J. Ryan M.D.
(Address) 5400 Arsenal St.

15. FILED AUG 11 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-9 1930

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930 to Aug 9, 1930 that I last saw h. e. alive on 8-9, 1930 and that death occurred, on the date stated above, at 4 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1a Lobar Pneumonia
1b
1c
(duration) 2 yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) John J. Ryan, M. D.
8-9, 1930 (Address) 5400 Arsenal St.

*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 Concordia Cem. DATE OF BURIAL Aug. 12 1930

20. UNDERTAKER Wm Schumacher ADDRESS 3013 Meramec

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.