

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

Do not use this space.

28340

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1093**  
 City **St. Louis** (No. **5713**, **Etyel Ave**) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. **8195**

**2. FULL NAME**

**Matilda Bullinger**  
 (a) Residence. No. **5713 Etyel Ave** St. **75** Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Female</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Widow</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Cyriach Bullinger</b>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>May 6, 1854</b>		
7. AGE YEARS <b>76</b>	MONTHS <b>3</b>	DAYS <b>9</b>
If LESS than 1 day, ..... hrs. or ..... min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... <b>None</b> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....		

9. BIRTHPLACE (CITY OR TOWN)..... **Georgia**  
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <b>Carl H. Krausch</b>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <b>Germany</b>
	12. MAIDEN NAME OF MOTHER <b>Unknecht</b>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <b>Germany</b>

14. INFORMANT **Charles Bullinger**  
 (Address) **5713 Etyel Ave**

15. FILED **17 1930**  
**W. C. Stover**  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 19 1930**

17. I HEREBY CERTIFY, That I attended deceased from **8/13/30** 19 to **8/15/30** 19 that I last saw her alive on **8/13/30** 19 and that death occurred, on the date stated above, at **9:15 P.M.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Septicemia**  
**36** (duration) yrs. mos. ds.  
**Infection of foot** (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY)  
**Infection of foot** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH..... **Infection of foot**  
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?..... **No**  
 WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) **Sam Bexced**, M. D.  
**8/16 1930** (Address) **5427 Delmar Blvd**

\*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 <b>Calvary Cemetery</b>	DATE OF BURIAL <b>Aug 18, 1930</b>
20. UNDERTAKER <b>Frehmann Harold</b>	ADDRESS <b>1905 Union</b>

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.

