

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

Do not use this space.

28384

File No. _____
Registered No. **8259**
St. _____ Ward)

1. PLACE OF DEATH

County..... Registration District No. **79E**
Towship..... Primary Registration District No. **1003**
City of **St. Louis Mo.** (No. **2540 Montgomery**)

2. FULL NAME

Minnie Beaver
(a) Residence. No. **2540 Montgomery** St., ~~Ward~~ **20** (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. **12** 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 (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 9 - 1878**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 | **—** | **9**

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) **Hannocki Miss**
(STATE OR COUNTRY) **Ill.**

10. NAME OF FATHER **Wm. Sebode**

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

12. MAIDEN NAME OF MOTHER **Anna Ferke**

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

14. INFORMANT **Claude Matter**
(Address) **2546 Montgomery St.**

15. **AUG 19 1930** FILED **W. E. Stoveng** REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug. 18 1930**

17. I HEREBY CERTIFY, That I attended deceased from **8-13**, 19**30**, to **8-17**, 19**30**, and that I last saw h. or alive on **8-17**, 19**30**, and that death occurred, on the date stated above, at **8:30** a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1. Apoplexy cerebral hemorrhage
2. Chronic myocarditis, hypertensive
3. Chronic
CONTRIBUTORY (SECONDARY)

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

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

WHAT TEST CONFIRMED DIAGNOSIS? **Histology**
(Signed) **Dr. Matt Crome**, M. D.
8/18, 19**30** (Address) **5738 W. Pleasant**

*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 **Lutheran cemetery Collinsville Ill.** DATE OF BURIAL **Aug. 21 1930**

20. UNDERTAKER **Geo. M. Schroepfel** ADDRESS **Collinsville Ill.**

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.

