

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

Do not use this space.

28420

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo.** (No. **5808 Highland Avenue**)

File No.

Registered No. **8300**

St. Ward)

2. FULL NAME **Barbara Stuyvaert**

(a) Residence. No. **5808 Highland Avenue** St. **6** 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 Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John L. B. Stuyvaert**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 12, 1881**

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day,hrs. ormin.
	49	1	5	

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) **Illinois**
(STATE OR COUNTRY)

10. NAME OF FATHER **John Spielman**

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 **John Stuyvaert**
(Address) **5808 Highland Avenue**

15. FILED **AUG 20 1930** **W. E. Barker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **August 17th, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **June 2**, 19**30**, to **aug 17**, 19**30** that I last saw her alive on **aug 17**, 19**30**, and that death occurred, on the date stated above, at **8:50** P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

121
65
Chronic myocarditis chronic
(duration) yrs. **2** mos. **15** ds.

CONTRIBUTORY (SECONDARY) **Chronic Nephritis**
(duration) yrs. **2** mos. **15** ds.

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

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Joseph Hill**, M. D.

aug 18, 1930 (Address) **3636 Hubert**

*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 **Sunset Burial Park** **DATE OF BURIAL** **Aug. 20, 1930**

20. UNDERTAKER **Wacker, Halder** **ADDRESS** **2331 S. Brdwy.**

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.

