

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

Do not use this space.

28459

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. 6642a Gravois Avenue.) St. _____ Ward _____

File No. _____
 Registered No. 8361

2. FULL NAME Estelle Suttmoeller

(a) Residence. No. 6642a Gravois Avenue st. 2 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 14, 1920

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	10	7	7	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At School
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Missouri.
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Casper Suttmoeller</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>St. Louis, Missouri.</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Katherine Plattner</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>St. Louis, Missouri.</u> (STATE OR COUNTRY)

14. INFORMANT Casper Suttmoeller
 (Address) 2719 McHair Avenue

15. FILED Aug 22 1930 W. C. Harkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 21, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930 to Aug 21, 1930 that I last saw him alive on Aug 21, 1930, and that death occurred, on the date stated above, at 9:20 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tubercular Meningitis
92A

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

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 Clinical Exam & Spinal
 (Signed) W. W. Gausler, M. D.
8-22, 1930 (Address) 3019 So Jefferson Ave.

*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. Paul Churchyard DATE OF BURIAL Aug. 23, 1930.

20. UNDERTAKER Wacker Halden ADDRESS 2331 S. Bldwy.

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.

