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.

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

Do not use this space. 28480

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 8382

City St Louis Mo (No. 5271 Genevieve Ave St. ..... Ward)

2. FULL NAME Clara Brinkmann

(a) Residence. No. 2125 De Soto St., 9 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): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 9th 1867

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
63	4	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Charles Riedel

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Mrs Elsie Kamp (Address) 2125 E De Soto Ave

15. FILED AUG 23 1930 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. No Physician in attendance

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 11.55 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broken Neck received when she fell down stairs at Residence

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Accident

(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) John Hurley M. D.

8/22, 1930 (Address) Deputy Coroner

*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 Peters — DATE OF BURIAL: Aug 23 1930

20. UNDERTAKER: Math Hermann & Son — ADDRESS: 2161 Fair Ave