

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

Do not use this space.

31404

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **5869**, **Wabada Ave**)..... St. Ward)

File No.
Registered No. **9010**

2. FULL NAME *Ida K. Sommer*

(a) Residence. No. **5869 Wabada Ave** St. **6** Ward. (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) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John C. Sommer**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 1, 1872**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
58 5 15

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) **St. Charles Co. Missouri**
(STATE OR COUNTRY)

10. NAME OF FATHER **Henry Boenker**

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

12. MAIDEN NAME OF MOTHER **Don't know**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **?**
(STATE OR COUNTRY) **Don't know**

14. NAME OF DECEASED **Mr. Clarence Sommer**

15. RESIDENCE **5869 Wabada Ave**

16. SIGNATURE **May C. Stanley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from **Sept 16 1930** to **Sept 16 1930** that I last saw her alive on **Sept 15 1930**, and that death occurred, on the date stated above, at **9:50 a.m.**

THE CAUSE OF DEATH WAS AS FOLLOWS:

**Labor Pneumonia
108**

CONTRIBUTORY (SECONDARY) **NO** (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 **all symptoms**
(Signed) **J. O. Thuesen**, M. D.

, 19 **1930** (Address) **6753 Page**

*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

DATE OF BURIAL

Valhalla Cemetery Sept 18 1930

20. UNDERTAKER

ADDRESS

Geo. L. Pleitach 5966 Easton Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state name, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Ida K. Sommer

SEP 17 1930

