

NOV 26 1930

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

Do not use this space.

33455

1. PLACE OF DEATH

County St. Louis

Registration District No. 50 #97

Township St. Louis

Primary Registration District No. 50 #97

City St. Louis

(No. 50 #97)

St. 157

Ward 157

2. FULL NAME Anna Regina Buntshalew

(a) Residence. No. St. 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.

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 W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 16 1894

7. AGE

YEARS 36

MONTHS 5

DAYS 25

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER John A. Buntshalew

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rosa Buntshalew

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis

(STATE OR COUNTRY)

14.

INFORMANT Anna Regina Buntshalew

(Address) St. Louis

15.

FILED 11-8-30

19.

W. A. Buntshalew

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10 1930

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., that I last saw him alive on....., 19....., and that death occurred, on the date stated above, at 11 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
140
36

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. J. Patney

M. D.

19

(Address) Marianne Mo

*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

St. Louis

Oct 12 1930

20. UNDERTAKER

ADDRESS

St. Louis

St. Louis

N. B.—Every entry on this form 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.

THE UNIVERSITY OF CHICAGO
PHYSICS DEPARTMENT
CHICAGO, ILLINOIS 60637

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 497 File No. _____
 Township St. Louis Primary Registration District No. 5673 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Anna Burkholder

(a) Residence. No. _____ St. _____ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____

(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____

(STATE OR COUNTRY) _____

14.

INFORMANT _____
 (Address) _____

15.

FILED _____

19. McCreason

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____, that I last saw him _____ alive on _____, 19____, and the death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septicemia
Marriage and infection (duration) yrs. mos. _____

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

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) P. J. Patrick, coroner
 , 19____ (Address) Manville, Mo

*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 _____

20. UNDERTAKER _____

ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK--THIS IS FOR PEWEEVEN, OH.

Every item of information should be carefully checked. Accuracy should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH as precisely as possible, so that it can be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-334155