

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

Do not fill this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1000*

File No. *38027*
Registered No. *11181*
Ward.....

2. FULL NAME

(a) Residence. No. *Regina Z. Gustman* St. *12* Ward. *Edwardsville Ill*
(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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 1 - 1897*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
33 10 24

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

9. BIRTHPLACE (CITY OR TOWN) *Strasburg*
(STATE OR COUNTRY) *Ill*

10. NAME OF FATHER *August Schulte*

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

12. MAIDEN NAME OF MOTHER *Sophia Beckman*

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

14. INFORMANT..... *August Schulte*
(Address) *Edwardsville Ill*

15. FILED *26 1930* *Max C. Harlow*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11 - 25 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 21 1930* to *Nov 25 1930*, that I last saw him alive on *Nov 24 1930*, and that death occurred, on the date stated above, at *1:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia (Streptococcus hemolyticus)
14 days (duration) yrs. mos. *10* ds.
CONTRIBUTORY *pneumonia Broncho*
(SECONDARY) *choked with*, *1 week*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *Edwardsville Ill*
DID AN OPERATION PRECEDE DEATH? *no* DATE OF *2*
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Chemical & bacteriological*
(Signed) *Joseph E. Glous*, M. D.
.19 (Address) *958 Arcade Bldg*

*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 *Edwardsville Ill* DATE OF BURIAL *11/26 1930*

20. UNDERTAKER *Mark & Weber* ADDRESS *Edwardsville Ill*

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.

