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

Do not use this space.

41180

File No.
Registered No. 11846

791
1003

1. PLACE OF DEATH

County ..... Registration District No. .....
Township ..... Primary Registration District No. .....
City (St Louis St. Louis Baptist Hospital (No. ..... St. ..... Ward)

2. FULL NAME HELEN SCHUERMANN

(a) Residence. No. 3525 N 9th St., 26 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4th 1870

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
60	3	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Badge Maker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Steiner Engraving Co

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

PARENTS
10. NAME OF FATHER Henry Winkel
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Mary Siebhoff
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Mathue Schuermann
(Address) 3525 N. 9th St.

15. FILED Dec 19, 1930 Harry C. Hartel REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-18- 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 -, 1930, to 12-18 -, 1930 that I last saw her alive on 12-18 -, 1930, and that death occurred, on the date stated above, at 2:35 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

121 Pus de uc Asthma
95B Chronic Pancreatitis
10 B ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic gastritis
Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? St Louis Baptist Hospital
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) D. M. Hamann M. D.
, 19 (Address) 2743 N Grand

*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 Calvary Cemetery — DATE OF BURIAL Dec 23d 1930
20. UNDERTAKER Edward Koch — ADDRESS 3516-14 14

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.