

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

Do not use this space.

41260

1. PLACE OF DEATH

County.....
Township.....
City *St Louis Mo* (No. *St Anthony Hospital*)

Registration District No. *791*
Primary Registration District No. *1008*

File No.....
Registered No. *11931* (Ward)

2. FULL NAME

Johanna Herzog
(a) Residence, No. *4311 Gibson St* Ward. *18*
(Usual place of abode)

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. (If nonresident, give city or town and State)

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 *John Herzog*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 16 1853*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>77</i>	<i>2</i>	<i>3</i>	

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

9. BIRTHPLACE (CITY OR TOWN) *St Louis Mo*
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <i>Martyr Schumann</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Not known</i>
	12. MAIDEN NAME OF MOTHER <i>Helen Cche</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Not known</i>

14. INFORMANT *Lena Schlattmann*
(Address) *4311 Gibson*

15. FILED *DEC 22 1933* *Max C. Hender* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-19-1930*

17. I HEREBY CERTIFY, That I attended deceased from *Sept. 2*, 19*30*, to *Dec. 19*, 19*30*, that I last saw him alive on *Oct. 19*, 19*30*, and that death occurred, on the date stated above, at *9* in.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis, Thrombosis of ganglion of legs Non Diabetic
Senile Arteriosclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *M*
(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?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *J. H. Weismann* M. D.
Dec. 22, 1933 (Address) *24110 St 9 St*

*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 Peter Paul* DATE OF BURIAL *Dec 23 1930*

20. UNDERTAKER *Hendle Hulle* ADDRESS *7819 Michigan*

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.

THIS IS A PERMANENT RECORD

