

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

Do not use this space.

41483

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St Louis (No. 4445 San Francisco)

File No.....

Registered No. 12170

St..... Ward.....

2. FULL NAME

(a) Residence. No. Maria Anna Naar St. 10 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 6 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Homework 131 106B
(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) Germany Austria

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14.

INFORMANT Sophie B. Naar
(Address) 4445 San Francisco

15.

FILED 29 1931 W. C. Stark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/28 1920

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 1920 to Dec 28 1920 that I last saw him alive on Dec 28 1920 and that death occurred, on the date stated above, at 6:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bright disease of
dropper and also had
urinary catheter had some
about 29 yrs (duration) yrs. mos. ds.

CONTRIBUTORY Heart failure
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

10915 don't know

8. DID AN OPERATION PRECEDE DEATH? DATE OF no

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Water + Stain of the
(Signed) W. A. E. Frye M. D.

19 (Address) 4471 Manchester Ave.

*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

Memorial Park Cemetery 12/30 1920

20. UNDERTAKER ADDRESS

Wm Schmader 4734 Nat Bridge

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.

