MAR 27 1931

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

Do not use this space.

2714

File No.
Registered No.

1. PLACE OF DEATH
County St Louis
Township St Ferdinand
City — (No. , St. Ward)
Registration District No. 784
Primary Registration District No. 6030

2. FULL NAME Margareth M. Weltner RONAN
(a) Residence. No. 5714 Helen ave 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 20th 1866

7. AGE: Years 74 Months 3 Days 23 If LESS than 1 day, hrs. or min.

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

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

PARENTS
10. NAME OF FATHER John Bowers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Margareth Wilson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind
(STATE OR COUNTRY)

14. INFORMANT John Ronan
(Address) 3953 a St Ferdinand

15. FILED Jan 19th 1931 Dr. Carl J. Kromer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 12 1931

17. I HEREBY CERTIFY, That I attended deceased from 1-10-31, 19, to 1-12-31, 19, that I last saw her alive on 1-12-31, 19, and that death occurred, on the date stated above, at 4 45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

HBP Chronic Nephritis
HBP
131 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cancer stomach
6 months (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? Yes DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Nurses
(Signed) Harlan Ling M.D.
, 19 (Address) 5076 Lindell

*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 Jan 15 1931

20. UNDERTAKER Edward Koch
ADDRESS 3516 Lyth

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD