

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.

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

Do not use this space.

2871

PLACE OF DEATH

County *St. Louis*

Registration District No. *1123*

Township *Carondelet*

Primary Registration District No. *6225 C*

City *St. Louis* (No. *803 Wachtel Ave*)

File No.

Registered No. *21*

St. _____ Ward)

2. FULL NAME *Antonia Sommer*

(a) Residence. No. *803 Wachtel 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

Male

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

Sophie Sommer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 12 1848*

7. AGE

YEARS *82*

MONTHS *11*

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Laborer 227*

(b) General nature of industry, business, or establishment in which employed (or employer) *Not known*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany 10*

PARENTS

10. NAME OF FATHER *Antonia Sommer*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT *Godfrey Sommer*
(Address) *803 Wachtel Ave*

15. FILED *1-15* 19 *L. C. Oborn* 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 *Jan 1*, 19*30*, to *Jan 12*, 19*31* that I last saw him alive on *Jan 12*, 19*31*, and that death occurred, on the date stated above, at *2 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dilatation of Heart
106 B
95 B (duration) *2* yrs. *2* mos. *2* ds.

CONTRIBUTORY (SECONDARY) *Bronchitis* (duration) *2* yrs. *2* mos. *2* ds.

18. WHERE WAS DISEASE CONTRACTED

106 B
NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *A. W. Peter* M. D.

Jan 12 1931 (Address) *601 Missouri 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 *St. Alice* DATE OF BURIAL *Jan 16/31*

20. UNDERTAKER *Fendler Hud Co* ADDRESS *7819 Michigan*

