

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

Do not use this space.

4058

1. PLACE OF DEATH

County..... Registration District No. 791
 Townshp..... Primary Registration District No. 1003
 City St. Louis (No. ISOLATION HOSPITAL)
 Registered No. 1338 Sl. Ward

2. FULL NAME

Delores Melschhoff
 (a) Residence, No. 1333 North Market 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 3 yrs. 4 mos. 7 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 24, 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 4 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work nil
 (b) General nature of industry, business, or establishment in which employed (or employer) 10 107th
 (c) Name of employer

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

10. NAME OF FATHER Harry Melschhoff

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Maria Brembs

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Mo.

14. INFORMANT Lorraine Kroner
 (Address) ISOLATION HOSPITAL

15. FILED FFS-3 BY May C. Starck
 19 1931 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-31 19 31

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1931, to Jan 31, 1931, that I last saw h. alive on Jan 31, 1931, and that death occurred, on the date stated above, at 11:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diphtheria-taricel
and Pharyngeal
 (duration) yrs. mos. 15 ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia
secondary (duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? no DATE OF 10
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Cluoid fluid
 (Signed) L. F. Kompars, M.D.
 , 19 (Address) ISOLATION HOSPITAL

*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 New Bethlehem DATE OF BURIAL Feb. 3 1931

20. UNDERTAKER Mat. Hermann ADDRESS 2161 E. Fair On

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.

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