

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

Do not use this space.

16114

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hosp.**)
546

File No.
Registered No. **4591**
St. Ward)

2. FULL NAME

(a) Residence. No. **City Hospital** St. **23** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **40** 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)

single

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

Nov 18-1880

7. AGE (MONTH, DAY AND YEAR)

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
50	4	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Laundress*
(b) General nature of industry, business, or establishment in which employed (or employer) *238*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Ireland*

10. NAME OF FATHER *Thos. Verlin*

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

12. MAIDEN NAME OF MOTHER *Maria Berger*

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

14. HOSPITAL INFORMATION
INFORMANT *Grace Lopp*
(Address) *City Hospital*

15. FILED *16 1931*
REGISTRAR *C. J. ...*

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 15th 1931*

17. I HEREBY CERTIFY, That I attended deceased from *April 9th 1931, to April 15th 1931*
that I last saw her alive on *April 15th 1931*, and that death occurred, on the date stated above, at *8:45 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bilateral lobar Pneumonia
100
100 (duration) yrs. mos. ds.
CONTRIBUTORY *Chronic nephritis*
(SECONDARY)
Arteriosclerosis of heart (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID IN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *serical + Autopsy*

(Signed) *J. Scherman* M. D.

4/15 1931 (Address) *City 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

Calvary

DATE OF BURIAL

4/18/31

20. UNDERTAKER

Strook Carroll

ADDRESS

4600 North Broadway

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.

