

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

Do not use this space.

16346

1. PLACE OF DEATH

County..... Registration District No. **701**

Township..... Primary Registration District No. **1003**

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

File No.....

Registered No. **4856**

St..... Ward)

2. FULL NAME

(a) Residence. No. **3911 Potomac St.** Ward. **16**
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **55** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widowed**
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct. 11 - 1857**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 6 10

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).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Iowa**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Hospital Joseph Hosp.**
(Address) **City Hosp.**

15. FILED **22 1931** **May C Parker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 21st 1931**

17. I HEREBY CERTIFY, That I attended deceased from **April 20th 1931** to **April 21st 1931** that I last saw her alive on **April 21st 1931** and that death occurred, on the date stated above, at **4:30 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

050
Carcinoma of Breast
Left
1474
..... (duration) yrs. mos. da.
CONTRIBUTORY **Broncho Pneumonia**
(SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH **3911 Potomac**

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF **✓**

20. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Ben Margulies**, M. D.

4/22 1931 (Address) **City Hosp.**

*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
St. Mary Ho. **4-23-1931**

20. UNDERTAKER ADDRESS
Alvin Hood Flat River Mo

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.

