

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

Do not use this space.

16520

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. **5041**
City *St Louis Mo* (No. *5079*, *H. Kauschickway Blvd*)..... Ward)

2. FULL NAME

Pessie A Kleinschmidt
(a) Residence. No..... St. *7* Ward..... (If nonresident, give city or town and State)
(Usual place of abode)
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*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 2nd 1875*
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
55 7 23

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *at Home 235*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

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

PARENTS
10. NAME OF FATHER *Unknown German*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Not known*
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) " "

14. INFORMANT *Edwin J Kleinschmidt*
(Address) *5079 H. Kauschickway*

15. FILED *27 1931*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 25 1931*
17. I HEREBY CERTIFY, That I attended deceased from *June 19 1929* to *April 25 1931* that I last saw *her* alive on *April 15 1931* and that death occurred, on the date stated above, at *3:15 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
metastatic carcinoma
50
53F

(duration) *2* yrs. mos. ds.
CONTRIBUTORY *carcinoma Breast (Bost.)*
(SECONDARY) (duration) *6* yrs. mos. ds.

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

3 DID AN OPERATION PRECEDE DEATH. *yes* DATE OF *6/11 29*
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS *Rubystay*
(Signed) *Arthur Sullivan M.D.*
4/27 1931 (Address) *2202 Linnwood St*

*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 *April 28 1931*

20. UNDERTAKER *Math. Heermann & Son 2161 Fair Can*
ADDRESS

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.

