

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

Do not use this space.

19446

**1. PLACE OF DEATH**

County..... Registration District No. 791

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

City St. Louis (No. City Hospital)  
20366

File No. ....  
Registered No. 5398  
St. .... Ward)

**2. FULL NAME**

(a) Residence No. 3814 no. Market Ward. 11

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 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 (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17-1898

|        |           |        |           |                                  |
|--------|-----------|--------|-----------|----------------------------------|
| 7. AGE | YEARS     | MONTHS | DAYS      | IF LESS than 1 day, hrs. or min. |
|        | <u>33</u> |        | <u>20</u> |                                  |

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) 235  
(c) Name of employer

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

10. NAME OF FATHER Robt. Wearhan

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

12. MAIDEN NAME OF MOTHER Maggie Caldoon

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

14. Informant Grace Kapp  
(Address) City Hospital

15. FILED 1944 May 11 1944 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21st, 1931, to May 7th, 1931, and that I last saw her alive on May 7th, 1931, and that death occurred, on the date stated above, at 7:20 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Pulmonary Tuberculosis  
235

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 23  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? refused

WHAT TEST CONFIRMED DIAGNOSIS Clinical Lab + X-Ray  
(Signed) V. Scherman, M. D.

577, 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 DATE OF BURIAL

Calvary May 8 1931

20. UNDERTAKER ADDRESS

Wm Paschdag 2825  
Market

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

