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

Do not use this space.

23295

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 6759

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis, Mo (No. 4371 Delor St. ..... St. ..... Ward)

2. FULL NAME Sallie Brinkmeier

(a) Residence. No. 4371 Delor St. St., 15 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 30-1854.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
76	8	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Work

(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) St. Louis Mo.

PARENTS

10. NAME OF FATHER Not Known

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Caroline Wagner
(Address) 437 Delor St.

15. FILED JUN 21 1931 19 Max C. Harlow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1931.

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1931, to June 19, 1931 that I last saw her alive on June 19, 1931, and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gangrene of both Legs (arteriosclerotic type)
131
97
9 R B (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1. Hypertension 2. Arteriosclerosis 3. Nephritis Chronic (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? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical findings

6/20 (Signed) W. H. Burroughs M.D.

1931 (Address) 4755 Morganford Rd

*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. Pauls Churchyard	6/22 1931.

20. UNDERTAKER	ADDRESS
Ziegenhein Bros. 2623 Cherokee St.	

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.