

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

St. Louis

(No. *5475* *Genesive*)

26337

File No.....

Registered No.....

7477

St. Ward)

2. FULL NAME

Louise Dillman

(a) Residence. No.

5475 Genesive St.

7 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *70* 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)

Widowed

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

Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 2, 1862

7. AGE

YEARS
69

MONTHS
1

DAYS
29

If LESS than 1 day, hrs. or min.

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).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Peter Engelhardt

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

Germany

14.

INFORMANT.....

(Address)

Mary Schmale

5475 Genesive St.

15.

FILED.....

May 10 1931

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

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

July 1, 1931

17.

I HEREBY CERTIFY that I attended deceased from *June 1, 1931* to *July 1, 1931*.
I last saw her alive on *July 1, 1931* and that death occurred, on the date stated above at *445P.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Myocarditis chr.
93C
CONTRIBUTORY *Nephritis (Chronic interstitial)*
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?.....

DATE OF.....

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *A. J. Hoffman* M. D.

7/31, 1931 (Address) *3458 S. Grand 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

DATE OF BURIAL

Walshalla Crematory July 4, 1931

20. UNDERTAKER

ADDRESS

Chudman & Sons 3934 N. 20

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.

