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. ..... File No. 29433

Township ..... Primary Registration District No. ..... Registered No. 8419

City St. Louis (No. 3709, S. Jefferson St. ..... Ward)

2. FULL NAME Catharine Seibert

(a) Residence. No. 3709 South Jefferson St., 24 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 20 1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	68	8	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Germany

PARENTS

10. NAME OF FATHER Unknown Kaltenschnee

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Peter Seibert
(Address) 3709 S. Jefferson

15. FILED AUG - 8 1931 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) AUG 1 - 1931 19

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Aug 1st, 1931 that I last saw her alive on July 31st, 1931, and that death occurred, on the date stated above, at 5:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82 Apoplexy (Cerebral)
77
102 (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis with Chron Hypertension (duration) 1 yrs. 9 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? Blood pressure

(Signed) H. C. Clapper, M. D.
8/1, 1931 (Address) 3803 S. Broadway

*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
Concordia Cemetery	8/4 1931
20. UNDERTAKER	**ADDRESS**
Theo. H. Beiderwieden	1936 St. Louis

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.