

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

Do not use this space.

File No. **14469**
Registered No. **3834**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **203**
City **St. Louis** (No. **City Hospital**)

2. FULL NAME

(a) Residence, No. **1304 St. Angelo** 22 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred **48** 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 **widowed** (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept. 11 - 1883**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
48 7 7

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Attendant**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **City Hospital**

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

13. NAME **Frank Slezak**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Hungary**

15. MAIDEN NAME **Mary Bender**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Hungary**

17. INFORMANT (ADDRESS) **City Hospital**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New St. P. + Paul** DATE **Apr 22 1932**

19. UNDERTAKER (ADDRESS) **Wacker House**

20. FILED **APR 19 1932** **Max C. Stankert** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 18th 1932**

22. I HEREBY CERTIFY, That I attended deceased from **April 8th 1932 to April 18th 1932**
I last saw her alive on **April 18th 1932** Death is said to have occurred on the date stated above, at **7:45 P.M.**
The principal cause of death and related causes of importance were as follows:

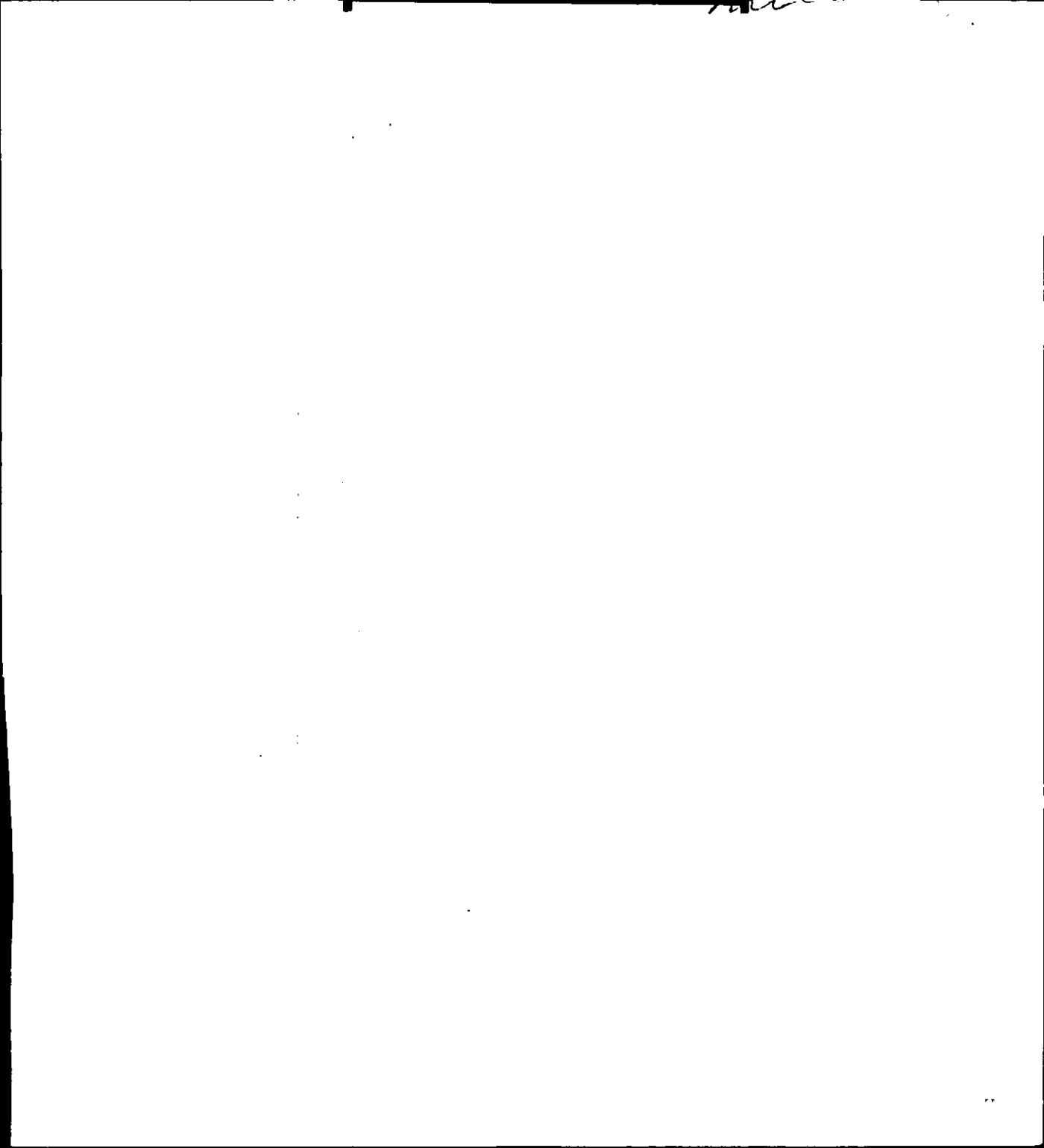
Chronic myocarditis
541
541
745

Other contributory causes of importance:
Pelvic peritonitis post operative cause mechanical
Name of operation **Hysterectomy** Date of **4-12-32**
What test confirmed diagnosis **Microsc.** Was there an autopsy **Yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____

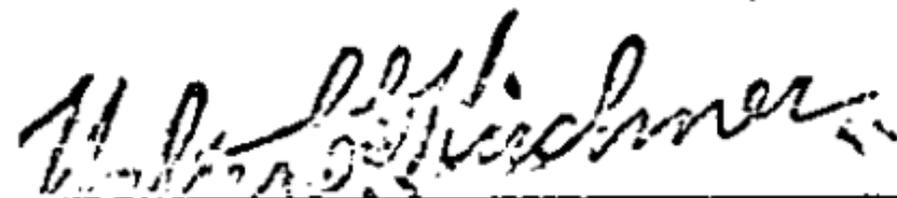
24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____ (Signed) **W. Miller** M. D.
(Address) **City Hospital**

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.



Mary Miller

Cause for which operation was performed - fibro-myoma of uterus. Supra-vaginal hysterectomy, bilateral salpingectomy, right oophorectomy performed April 12, 1932.



M.D.

Walter C. G. Kirchner
Medical Director

WCGK:FL

(52) - 14469

Apr 18, 1932

NO

23

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

3834

Name: Mary Miller

Who died at St. Louis, Mo. (City) on April 18, 1932, (Date)

Residence: No. _____ St. _____ (If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex _____ Color or race _____ Single, married, widowed or divorced: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or Country) _____

Birthplace of father (State or Country) _____

Birthplace of mother (State or Country) _____

Principal cause of death: Chronic Myocarditis

55B

Other contributory causes of importance: Chronic Pelvic Peritonitis Post-operative cause unknown

Name of physician _____ Date of death _____

What was the confirmed diagnosis? _____ Was there an autopsy? _____

If death due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town county and State)

Specify whether injury occurred in industry, home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Gynecology

S-14469