

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

Do not use this space.

18062

4263

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City St. Louis 700 (No. Missouri Baptist Hosp. Ward)

2. FULL NAME

(a) Residence. No. 2615 1/2 Minnesota Ave 17 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 1933

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

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1932, to May 12 1933, that I last saw him alive on May 12 1933, and that death occurred, on the date stated above, at 4:30 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 1885

18. THE CAUSE OF DEATH* as follows:
15 Eye replaced with
2 phlebotomy following

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 9 8

CONTRIBUTORY (SECONDARY) Typhemia
but 6 weeks
 (duration) yrs. mos. da.

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 At Home

18. WHERE DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: St Louis

9. BIRTHPLACE (CITY OR TOWN) St Louis
 (STATE OR COUNTRY) Mo 3

DID AN OPERATION PRECEDE DEATH? local abscess
new punctured and drained
 DATE OF
 WAS THERE AN AUTOPSY? by clinical

10. NAME OF FATHER Louis Stapp
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) P. J. Foreman, M. D.
 (Address) Metairie, La

12. MAIDEN NAME OF MOTHER Doc. Kuehnert
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

*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.

14. INFORMANT W. S. P. P. P.
 (Address) 215 S. 5th St. - Minn. Ave

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Hope Cemetery DATE OF BURIAL 5-15 1933

FILED 14 4 1933
W. S. P. P. P. REGISTRAR

20. UNDERTAKER Wm. J. Robert ADDRESS 1905 - S. Grand

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.

