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.

SEP 26 1933

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

Do not use this space.

28169

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 7279

City St. Louis (No. 1607, So. Jefferson St. ..... Ward)

2. FULL NAME Bertha Inauan

(a) Residence, No. 1607 S. Jefferson St., 23 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? 40 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: Arnold Inauan

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): January 14, 1885

7. AGE: Years 48 Months 7 Days 9 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: .....
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): Germany

FATHER
13. NAME: Unknown Schwarz
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

17. INFORMANT (ADDRESS): Hugo Schwarz 1607 S. Jefferson Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Park Lawn Cemetery DATE: Aug. 24, 1933

19. UNDERTAKER (ADDRESS): Witt Bros. L. & U. Co. 2929 So. Jefferson Ave.

20. FILED: AUG 2 1933 19 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

No physician in attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug. 23, 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 12:05 P.m.

The principal cause of death and related causes of importance were as follows:

Asphyxiation due to Fuel Gas Poisoning self administered at residence — Aug. 23 1933

Suicide

Other contributory causes of importance: 164A 164

Date of onset

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No

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) John J. Sweeney

(Address) Deputy Coroner

8/24/33