

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

Do not use this space.

37831

1. PLACE OF DEATH *St. Louis*
 County *St. Louis* Registration District No. *1123*
 Township *Carondelet* Precinct Registration District No. *1628* File No. _____
 City *St. Louis* (No. *11*) *North Hospital* St. _____ Registered No. *355* Ward _____

2. FULL NAME *Bertha Hoppe*
 (a) Residence No. *Halilton* St. _____ 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? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*
 4. COLOR OR RACE *W*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lucy Hoppe*
Widowed

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64

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) (STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *Unknown*

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*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11/14* 19*33*

17. I HEREBY CERTIFY, That I attended deceased from *9/1/33* to *11/14* 19*33*
 that I last saw her alive on *11/14* 19*33*, and that death occurred, on the date stated above, at *7:53* P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
*Arteriosclerosis (Coronary sclerosis)
 Chronic myocarditis.
 Unknown (duration) yrs. mos. ds.
 Pulmonary tuberculosis (healed)
 Unknown (duration) yrs. mos. ds.*

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *X-ray*

(Signed) *Paul Merwin*, M. D.
 (Address) _____

*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 *Vallejo Crematorium* DATE OF BURIAL *Nov 16 1933*

20. UNDERTAKER *Callan-Kelly* ADDRESS *1416 N. Taylor*

14. INFORMANT *Carl Hoff*
 (Address) *1445 Lottion out*

15. FILED *Nov 16 33* L. C. Obrock M.D. REGISTRAR

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.

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