

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.

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

Do not use this space.

File No. *ms 3518*

1. PLACE OF DEATH

County *St. Louis* Registration District No. *1160*
Township *Central* Primary Registration District No. *4470*
City *University City* (No. *7539*) *Wayne Ave.*, St. _____ Ward _____

2. FULL NAME

Lobisa Hartmann
(a) Residence, No. *7539 Wayne Ave.* Ward, _____
(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. (If nonresident, give city or town and State)

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 *Fred Hartmann*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 7 = 1843*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 7 23

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

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*

13. NAME *Carnest Mueller*

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

15. MAIDEN NAME *Don't know*

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

17. INFORMANT (ADDRESS) *Mrs. Emma McGubine 7539 Wayne Ave.*

18. BURIAL, CREMATION, OR REMOVAL *St. Peter Cem. DATE Feb. 2, 1934*

19. UNDERTAKER (ADDRESS) *Jos. W. Clark 1125 Hodiamont Ave.*

20. FILED *Feb. 1, 1934* *Lena V. Moeller* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan. 30, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *May 15, 1932* to *Jan 30, 1934*

I last saw h. er. alive on *Jan 30, 1934* Death is said to have occurred on the date stated above, at *11 P. m.*

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

*Fractured hip
Myocarditis
arterio-sclerosis*

Date of onset *2-1-34*

Other contributory causes of importance: *auricular fibullosis*

Name of operation *none* Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? *No.*

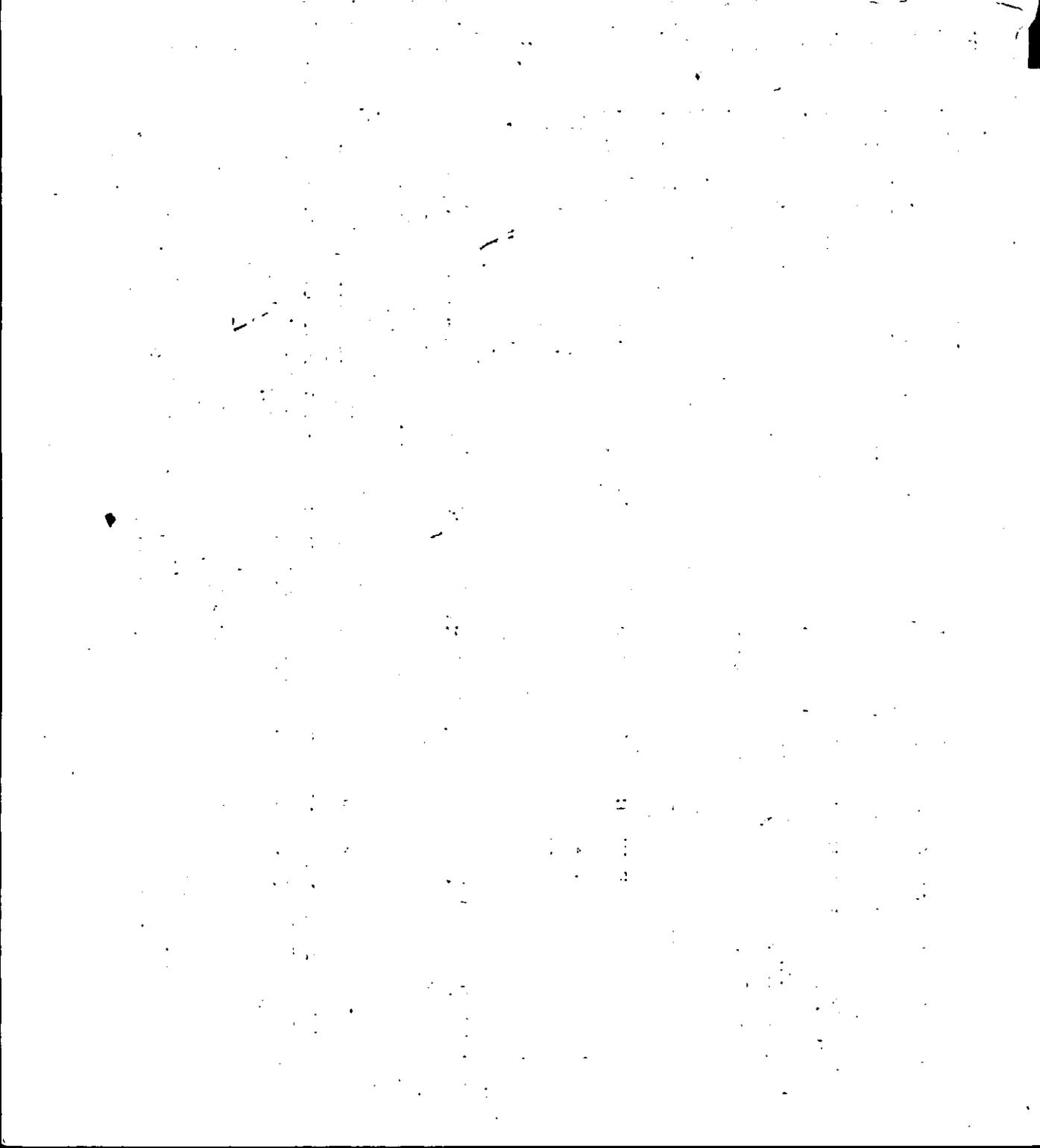
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)

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

Manner of injury _____
Nature of injury _____

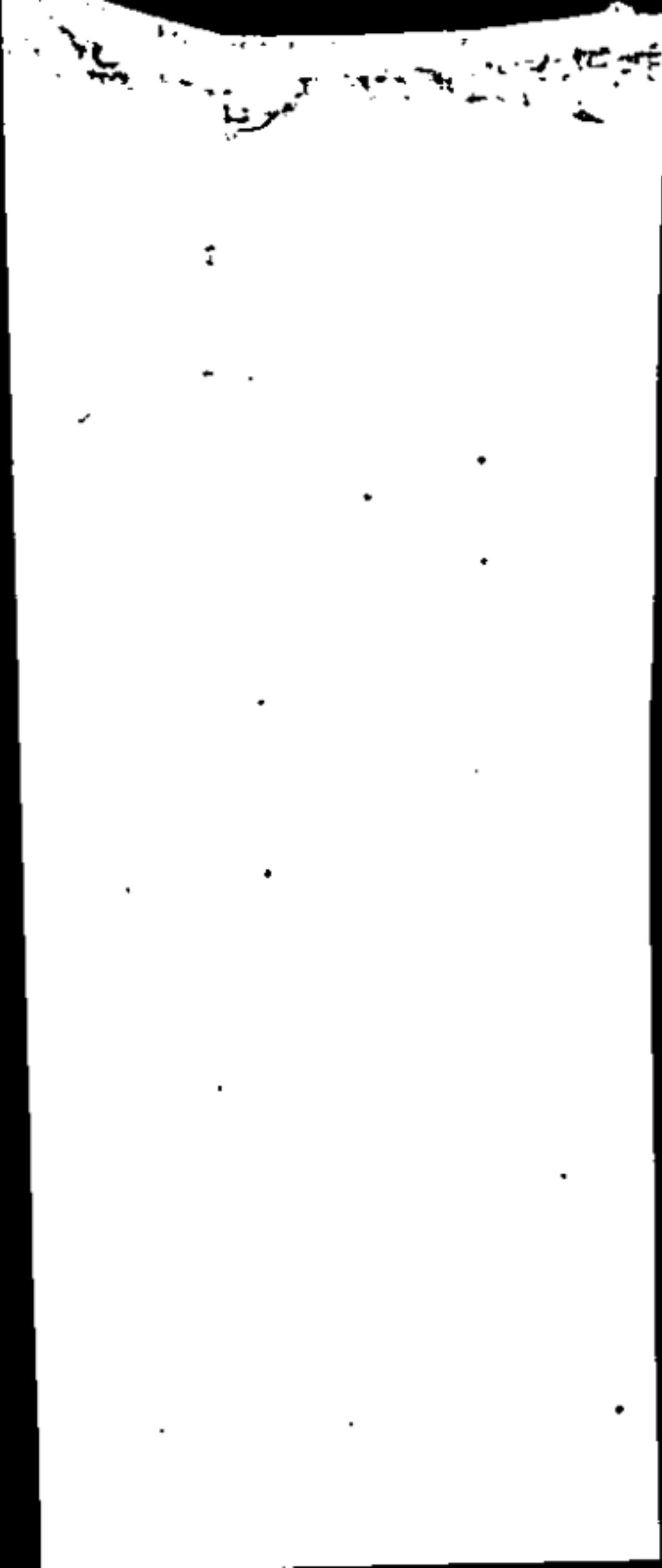
24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) *Jos. L. Gross* M. D.
(Address) *6677 Delmar*



Please note that this information is supplied by Dr. Geo. E. Zukovich who attended Louisa Hartman while at the hospital.

Dr. Jos. L. Gross who signed the death certificate attended Louisa Hartman after she left the hospital.



St. Louis Co.

BUREAU OF THE CENSUS

WASHINGTON

3518

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Dear Sir:

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.

Name: *Louisa Hartman*

Who died at _____ on *Jan. 30 - 1934*

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: *Fractured Hip. (Caused by Fall)*

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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

Accident, suicide, or homicide? _____ Date of injury *Aug 1, 1933*

Where did injury occur? *X In kitchen of her home - University City Mo.*
(Specify city or town, county and State)

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

Manner of injury *X Home* *Became dizzy + fell down on Rt Hip*

Nature of injury *X Fractured right femur*

Was disease or injury in any way related to occupation of deceased? *X No*

If so, specify *X*

Name of physician *Dr. E. Zubovels, M.D.*

Address of physician *St. Louis County Hospital*

Signature of Registrar *Lena J. Moeller* Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. *1160*

Primary Reg. Dist. No. *4470*

E. T. Mc Gaugh
Special Agent. *m. d.*

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