

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MAY 25 1934

14527

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **St. Louis No. 5921, Saloma Ave** St. _____ Ward _____

File No. _____
Registered No. **3708**

2. FULL NAME

(a) Residence, No. **5931 Saloma Ave** 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 **Female**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 15, 1873**
7. AGE YEARS **60** MONTHS **8** DAYS **37**
IF LESS than 1 day,hrs. ormin.
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) **St. Louis Mo**

13. NAME **Washington Miller**

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

15. MAIDEN NAME **Sophias Koch**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Wassersburg Mo**

17. INFORMANT **Henry F. Seep**
(ADDRESS) **5931 Saloma Ave**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **New Bethel Cem** DATE **Apr 14 1934**

19. UNDERTAKER **Math. Hermann and Son**
(ADDRESS) **3616 Oak Fair Ln.**

20. FILED **57 1934** 19. **J. M. Bredbeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Apr 11 1934**

22. I HEREBY CERTIFY, That I attended deceased from **June 6 1931**, to **Apr 11 1934**

Last saw her alive on **Jan 3 1934**. Death is said to have occurred on the date stated above, at **5:30 P. m.**

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

Progressive Spinal Paralysis (Paralysis) Date of onset **Dec 1936**

Other contributory causes of importance:

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

What test confirmed diagnosis? **Clinical** 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.....

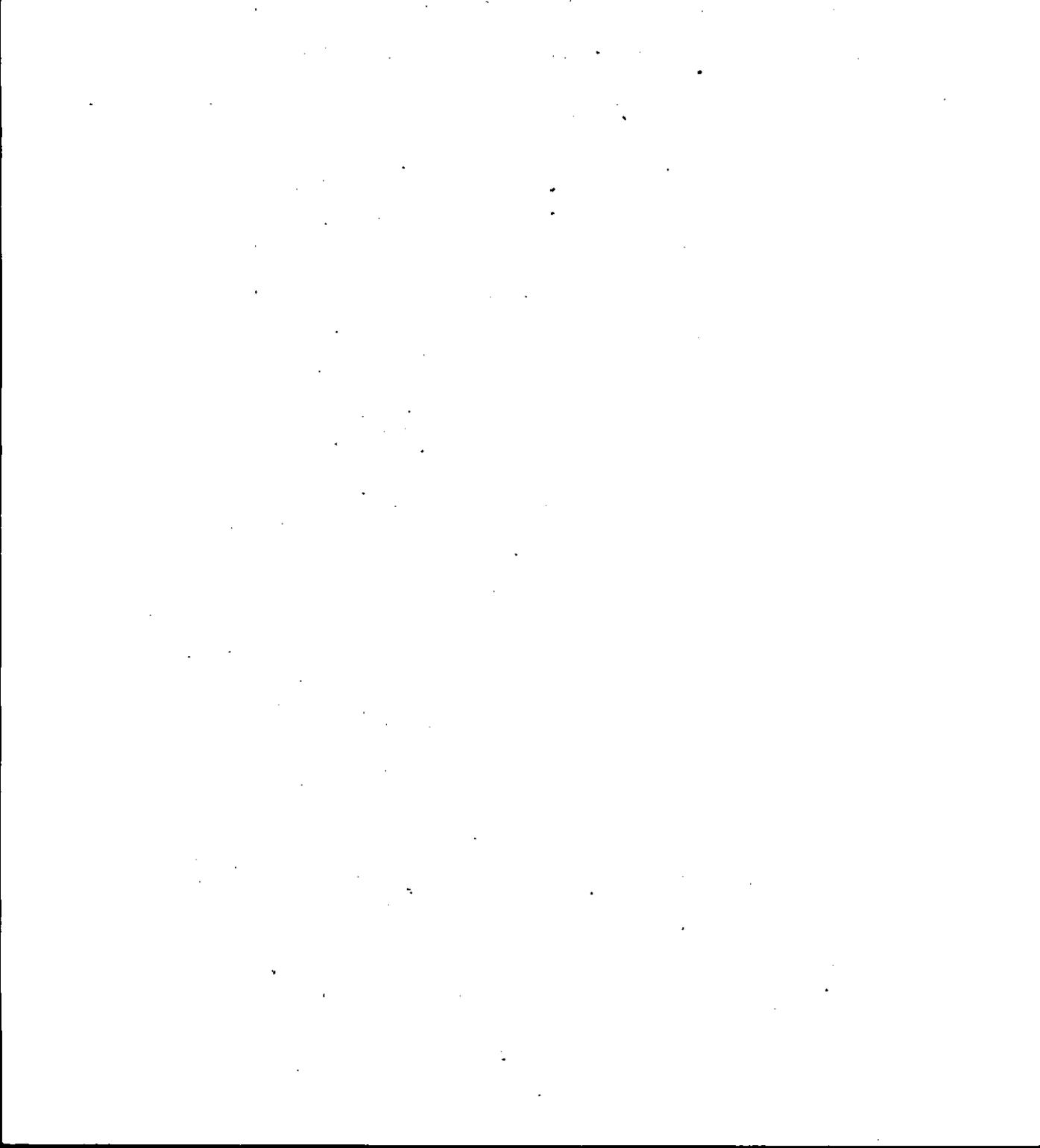
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no**

If so, specify.....

(Signed) **Geo. Mellie**, M. D.

(Address) **2743 N. Grand**



14527

3708

St Louis City

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: Christina Reep
Who died at _____ on Apr 11 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years 60 Months 8 Days 27

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) (Paraguay)
Birthplace of father (State or country) Non lactic
Birthplace of mother (State or country) Non lactic
Principal cause of death: cause unknown

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 _____, 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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician Geo A Mellus
Address of physician 2743 N Grand
Signature of Registrar [Signature] Date filed 11-2-34

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.

Reg. Dist. No. _____ Very truly yours,

Primary Reg. Dist. No. _____
E. T. McLaugh
Special Agent. State Registrar

S-14527