

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

Do not use this space. 604  
77

MAY 25 1934

**1. PLACE OF DEATH**

County..... Registration District No..... File No. **14553**  
 Township *St. Louis* Primary Registration District No. **791** Registered No. **3736**  
 City *St. Louis* (No. *East 10th St.*) **1000** St. .... Ward)

**2. FULL NAME**

(a) Residence, No. *2567 W. Hubert St.* Ward. *20* (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*) *single*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar 30. 1934*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *13*

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

MOTHER FATHER 13. NAME *Lawrence Gerber*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis mo.*

15. MAIDEN NAME *Thekla Piotowski*

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

17. INFORMANT *Lawrence Gerber*  
 (ADDRESS) *2567 W. Hubert*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Nashville Ills* DATE *Apr 14 1934*

19. UNDERTAKER *Thos. G. Curtis*  
 (ADDRESS) *2906 Grayson ave.*

20. FILED *17 1934*  
*J. H. Brebeck*  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

*W. P. H. Secor M.D. in attendance*  
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Apr 13 1934*

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 *1:00 A.M.*

The principal cause of death and related causes of importance were as follows:  
*chronic pneumonia*  
*congenital disability*

Date of onset  
*10/12/15*  
 Other contributory causes of importance  
 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) *W. P. H. Secor*  
 (Address) *414 1/2 St. Louis*

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.



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: Thelma Lexter  
Who died at \_\_\_\_\_ on Apr 13 - 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 \_\_\_\_\_ Months \_\_\_\_\_ Days 13

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: Broncho pneumonia  
(Primary) Congenital disability

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 \_\_\_\_\_  
Address of physician \_\_\_\_\_  
Signature of Registrar J. Bredeck

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. 791

Primary Reg. Dist. No. 1003

Very truly yours,  
E. T. McLaugh M.D.  
Special Agent.

