

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City **ST. LOUIS**

Registration District No. **791**
Primary Registration District No. **1003**
(No. **Bethesda Hosp.**)

File No. **18181**
Registered No. **4640**
St. Ward)

2. FULL NAME

(a) Residence, No. **2818 Caroline St., 27** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **Life** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March-16-1850**

7. AGE YEARS **84** MONTHS **1** DAYS **20** If LESS than 1 day, hrs. or min.

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. **at Home**
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 Missouri**

13. NAME **unknown**

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

15. MAIDEN NAME **unknown**

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

17. INFORMANT (ADDRESS) **Arthur Strub 2818 Caroline**

18. BURIAL - CREMATION, OR REMOVAL PLACE **New St. Marcus** DATE **May-8-1934**

19. UNDERTAKER (ADDRESS) **A. St. M^o Laughlin 1631 Missouri Ave**

20. FILED **14V - 7 1934** **J. Brebeck** Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May-6-1934**

22. I HEREBY CERTIFY, That I attended deceased from **April 23, 1934, to May 6, 1934**
I last saw h.e.r. alive on **May 6, 1934**. Death is said to have occurred on the date stated above, at **1:40 p.m.**
The principal cause of death and related causes of importance were as follows:

1) **Myocardial Insufficiency** Date of onset
2) **Hypostatic Pneumonia**
Other contributory causes of importance: **108 930**

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? **No**

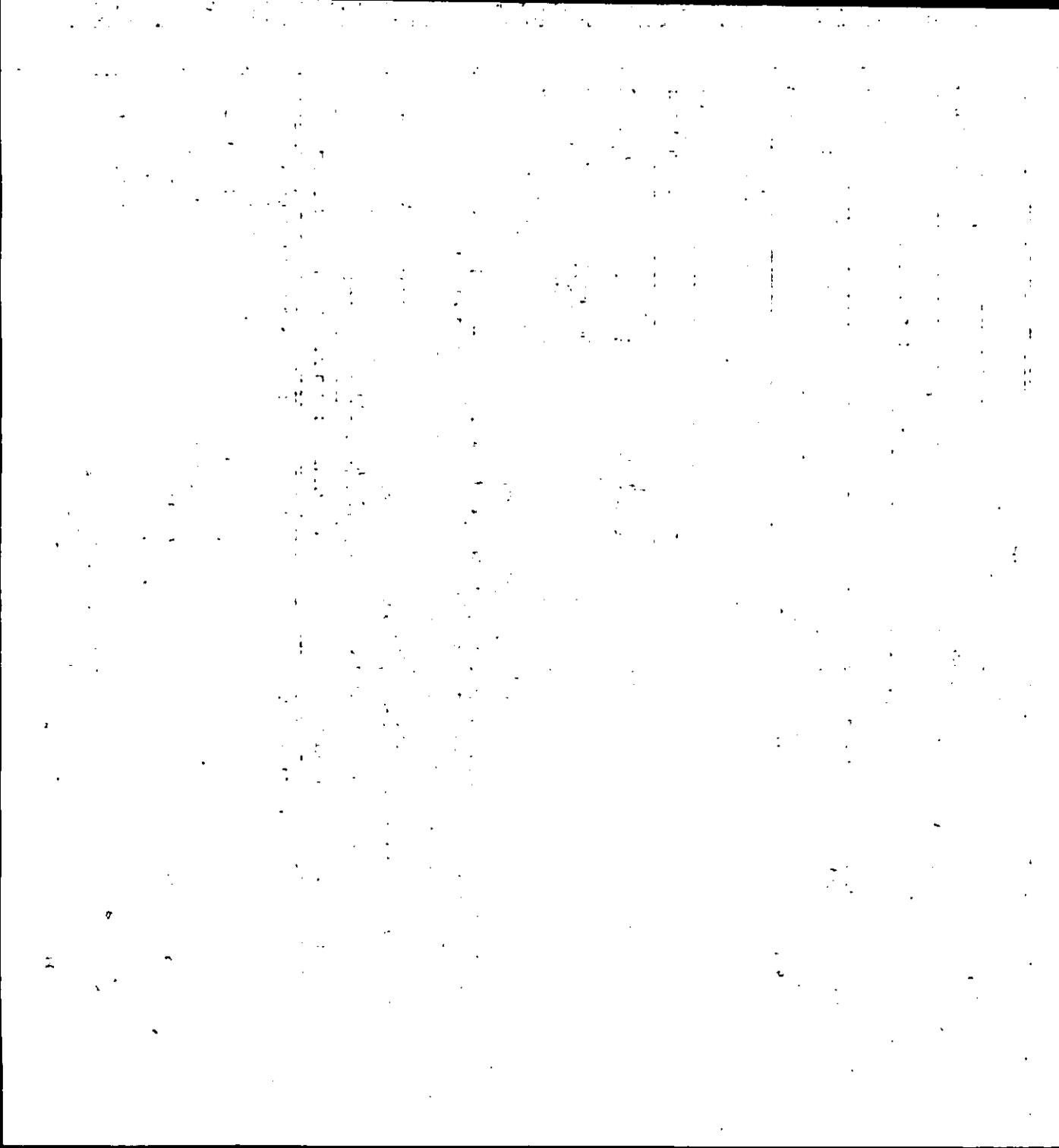
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify **Yes**
(Signed) **F. C. Creech**, M. D.
(Address) **3649 Victoria**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

JUN 19 1934



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 4640
St..... Ward.....

2. FULL NAME

(a) Residence, No. St. 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

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

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

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 91-34 J. F. Breuck Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6, 1934

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

I last saw him alive on, 19..... Death is said to have occurred on the m.

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

myocardial insufficiency Date of onset

lobar pneumonia

Other contributory causes of importance:

Lobar Pneumonia

Name of operation..... Date of

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

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) J. C. Creech, M. D.

(Address) 3649 Vista Ave

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

14181.5