

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **A. Louis**

(No. **American Hospital**)

File No. **26642**

Registered No. **6813**

St. Ward)

2. FULL NAME

Lina Preher (Preher)

(a) Residence. No. **4159^a Shaw** St., **17** Ward.

(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) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **1880-4-13**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
54 3 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **At home**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

10. NAME OF FATHER **Fred Wetzel**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Elizabeth Wetzel**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

14. INFORMANT **Elizabeth Wetzel**
(Address) **4159^a Shaw**

15. FILED **19 1934**
J. Predeck
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7-10 1934**

17. I HEREBY CERTIFY, That I attended deceased from **July 10-1934** to **July 10, 1934** that I last saw him alive on **July 10, 1934**, and that death occurred, on the date stated above, at **11:30 A. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of urinary bladder

CONTRIBUTORY (SECONDARY) **53 B** (duration) **4** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **X-Ray**

(Signed) **Hollie Shaver, M. D.**

. 19 (Address) **2800 N. Taylor**

*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 DATE OF BURIAL

Crownville, Mo. **7/11 1934**

20. UNDERTAKER ADDRESS

Robert Humboldt **2677**
Peoria

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.

AUG 15 1934

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