

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

Do not use this space.

APR 9 1935

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1. PLACE OF DEATH

County Registration District No.
Township Primary Registration District No.
City *St. Louis* No. *4988 a. Thibozan ave* St. Ward)

File No.
Registered No. *2926*
St. Ward)

2. FULL NAME

Emma Seiber (Emigley)

(a) Residence, No. *4988 a Thibozan* St., *14* 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 *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Married*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 18, 1852*
7. AGE YEARS *82* MONTHS *7* DAYS *8* If LESS than 1 day, hrs. or min.

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) *Germany*

13. NAME *William Gerhardt*

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

15. MAIDEN NAME *Johanna Pabst*

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

17. INFORMANT (ADDRESS) *Mrs Pauline Hetzler 4988 a Thibozan ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Memorial Park* DATE *3-29* 19*35*

19. UNDERTAKER (ADDRESS) *The G. Schaefer Spasharias 423 85th St*

20. FILED *MAR 23 1935* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-26* 1935

22. I HEREBY CERTIFY, That I attended deceased from *March 2-* 1935 to *March 26* 1935
I last saw her alive on *March 26* 1935. Death is said to have occurred on the date stated above, at *10:30 p.m.*
The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia.
82
Date of onset *March 2- 1935*

Other contributory causes of importance:
Cerebral hemorrhage - March 2- 1935
arterio sclerosis

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) *Peter A. Sch*, M. D.
(Address) *4701 St Louis Ave*

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.

4701a St Louis
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Em 6756