

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

Do not use this space.

MAY 23 1935

15013

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
Primary Registration District No. **1003**
(No. *St. Johns Hospital*)

File No. **3895**
Registered No.....
St..... Ward.....

2. FULL NAME

Margaret Mary Hahn

(a) Residence, No. *14394 Holly Hills* St. *7* 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*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Wm. P. Hahn*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 15, 1882*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 10 12

OCCUPATION 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*

MOTHER FATHER 13. NAME *John Rickhoff*

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

MOTHER 15. MAIDEN NAME *Geneva Wertheim*

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

17. INFORMANT *Wm. P. Hahn*
(ADDRESS) *4394 Holly Hills*

18. BURIAL, CREMATION, OR REMOVAL PLACE *New St. Charles* DATE *4-30-35*

19. UNDERTAKER *W. J. Hahn*
(ADDRESS) *4278 So. Trappan Highway*

20. FILED *APR 29 1935* *J. Bledsoe*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-27-1935*

22. I HEREBY CERTIFY, That I attended deceased from *4-26*, 1935, to *4-27*, 1935

I last saw h.c.t. alive on *4-26*, 1935 Death is said

to have occurred on the date stated above, at *1:30 p.m.*

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

Acute Cerebro Spinal Meningitis (Streptococci) (non-pneumonic) Acute Pharyngitis tonsillitis + Otitis Media (Streptococci)
Date of onset *4-25-35*
7/15-35

Other contributory causes of importance:

Name of operation *115 a* Date of.....

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. B. Lammont* M. D.
(Address) *Missouri Theatre Bldg.*

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.

MARON RESERVED FOR BINDING

V. 9 NO. 2
100M-11-24-33

