

APR 11 1936

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

Do not use this space.

12714

## 1. PLACE OF DEATH

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

Registration District No. **791**  
Primary Registration District No. **1003**  
No. *5630 Pershing ave*

File No.....  
Registered No. **2752**  
St. .... Ward)

## 2. FULL NAME

*Ann Dierkes*  
(a) Residence, No. *5630 Pershing* St., *5* 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) *single*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 27 1897*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*38* *6* *17*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *nil*  
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) *St. Louis* (STATE OR COUNTRY) *mo*

13. NAME *Bernard Dierkes*

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

15. MAIDEN NAME *Anna Von Hemann*

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

17. INFORMANT *Mrs. Bernice Gately* (ADDRESS) *Springfield St.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary* DATE *Mar 18<sup>th</sup>* 19*36*

19. UNDERTAKER *J. A. Sullivan & Sheldon Hall* (ADDRESS) *414 1/2 Washington Blvd*

20. FILED *1-2-1936* 19 *J. F. Brebeck* Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 11* 19*36*

22. I HEREBY CERTIFY, That I attended deceased from *Oct 1* 19*32* to *Mar 11* 19*36*

I last saw h. *ea.* alive on *Mar 11* 19*36* Death is said to have occurred on the date stated above, at *11:30 P.M.*

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

*Carcinoma of breast*

Other contributory causes of importance: *50*

*Arteriosclerosis*

Name of operation..... Date of.....

What test confirmed diagnosis? *Pathology* 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? *No*

If so, specify..... (Signed) *Walter H. Johnson* M. D.

(Address) *706 Century Bldg*

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.

