

MAY 7 1936

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

File No. 17725 4508

Township.....

Primary Registration District No. 1003

Registered No.

City *St. Louis* St. *St. Anthony's Hospital* Ward)

2. FULL NAME

(a) Residence, No. *2808 Wisconsin* St. *24* 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 *M.* 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 *Otto Bues*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *3-19-1878*7. AGE YEARS *58* MONTHS *1* DAYS *3* 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 *M. Hunt*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*15. MAIDEN NAME *Caroline Geiskert*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*17. INFORMANT *Otto Bues* (ADDRESS) *2808 Wisconsin*18. BURIAL, CREMATION, OR REMOVAL *None* (ADDRESS) *St. Peter's Paul* DATE *4-24-36*19. UNDERTAKER *Dr. C. Maydell* (ADDRESS) *Allegan*20. FILED *APR 27 1936* *J. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-22*, 19*36*22. I HEREBY CERTIFY, That I attended deceased from *April 18*, 19*36*, to *April 22*, 19*36*I last saw her alive on *April 21*, 19*36* Death is saidto have occurred on the date stated above, at *5:30 A.M.*

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

Lobar Pneumonia Date of onset *4/18/36**108*

Other contributory causes of importance:

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

What test confirmed diagnosis *Chlamydia* Was there an autopsy? *Yes*

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.....

(Signature) *Edith German*, M. D.(Address) *3924 Grand*

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.

