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.

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

30688

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. .....

or

Village ..... Primary Registration District No. 1003 Registered No. 8589

or

City St Louis (NO. 3504 Market St St. 16 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Wilhelmina Stifel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (~~Write~~ the word): Widow

6 DATE OF BIRTH: July (Month) 3 (Day), 1863 (Year)

7 AGE: 55 yrs. 2 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): St Louis

PARENTS

10 NAME OF FATHER: Jacob F Stifel

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

12 MAIDEN NAME OF MOTHER: Christine Kearcher

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma O Conner

(Address) 3504 Market St

15 Filed SEP 13 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 11 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 28, 1918, to Sept 11, 1918, that I last saw her alive on Sept 11, 1918, and that death occurred, on the date stated above, at 11.45 P.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

2 (Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Willard J Haas M. D.

9/12, 1918 (Address) 3240 Sollokoff

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Bellefontaine

DATE OF BURIAL: Sept 14, 1918

20 UNDERTAKER: Beiderwieden & Dunkman

ADDRESS: 1934 St Louis Ave

V. S. No. 2, A

MARGIN RESERVED FOR BINDING

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.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or

Village ..... Primary Registration District No. ..... Registered No. .....
or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work .....

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191..... that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS