

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

27137

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City *St. Louis* (No. *St. John's Hoop*)

File No.....
Registered No. *8054*
St..... Word.....

2. FULL NAME

(a) Residence. No. *6623 Chamberlain St.*, Ward *13* *St. Louis 20 Mo*
(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~~ *Married*
(write the word)

5A. IF MARRIED, ~~Give name and address of~~
(OR) WIFE OF *Charles Grieshaber*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 22 1892*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
34 2 21

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illnoise*

10. NAME OF FATHER *Laurinse Jacob*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

12. MOTHER'S NAME OF MOTHER *Mary Elie Thle*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

14. INFORMANT *Charles Grieshaber*
(Address) *6623 Chamberlain St.*

15. FILED *Aug 14 1926* *Marb. Starckoff*
Registered

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 13, 1926*
17. I HEREBY CERTIFY, That I attended deceased from *August 10, 1926*, to *August 13, 1926*, that I last saw her alive on *8-12-26*, and that death occurred, on the date stated above, at *7:45 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Toxic Gastric
Exophthalmic Goiter
CONTRIBUTORY (SECONDARY) *Thyroidectomy*

18. WHERE DID DISEASE COMMENCE? (LOCATION) (CITY OR TOWN) (STATE OR COUNTRY)
IF PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *August 13, 1926*

WHAT TEST CONFIRMED DIAGNOSIS? *Frank record*
(Signed) *Ed Murphy*, M. D.
Aug 14, 1926 (Address) *5330 Leona*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Genevieve* DATE OF BURIAL *Aug 14, 1926*

20. UNDERTAKER *Jos. W. Clark* ADDRESS *710*
Hodinson

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
U. S. No. 2.

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.

