

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

Do not use this space.

13089

**1. PLACE OF DEATH**

County.....St. Louis Mo......

Registration District No. 791

Township.....

Primary Registration District No. 1003

City.....St. Louis Mo......

(No. 4120 Grove.)

File No. ....

Registered No. 3386

St. .... Ward)

**2. FULL NAME Emma Richter.**

(a) Residence, No. 4120 Grove, St. St. 10 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)

Female White Widow.

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Herman Richter.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12/17/1859

7. AGE

YEARS

MONTHS

DAYS

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

67 3 19

**8. OCCUPATION OF DECEASED**

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

Housework.

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

Self.

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Germany.

**10. NAME OF FATHER**

Carl Wendt.

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Germany.

**12. MAIDEN NAME OF MOTHER Amelia Maggeline.**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Germany.

14.

INFORMANT

(Address)

Mrs Elizabeth Koch  
4120 Grove St

15.

FILED

NOV 8 1927

19

Max S. Starks  
REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/6/27 19

17.

I HEREBY CERTIFY, That I attended deceased from Mar 24, 1927, to April, 1927, that I last saw her alive on April 5, 1927, and that death occurred, on the date stated above, at 8 45 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Central apoplexy  
Hemorrhage

CONTRIBUTORY (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Urinal test

(Signed) John H. Sutter, M. D.

4/8, 1927 (Address) 6531 Bortner ave

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

DATE OF BURIAL

St. Peters.

4/9/27 19

**20. UNDERTAKER**

ADDRESS

Provoch & Co 3710 N. 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.

DEPARTMENT RECORD

