

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

Do not use this space.

13189

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* No. *4461*

File No.

Registered No. **3491**

St. Ward)

2. FULL NAME

(a) Residence. No. *4461 Sammett* St. *15* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *25* yrs. - mos. - da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF *Matter Nicholson*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 19 1871*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>55</i>	<i>5</i>	<i>20</i>	

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).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Attentown*
(STATE OR COUNTRY) *Penn'a.*

10. NAME OF FATHER *John Rend.*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Matter Nicholson*
(Address) *4461 Sammett.*

15. FILED *APR 11 1927* *Mau & Starckoff*
Registrars

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 9 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Apr 6* *6 April*, 19*27*, to *April 9*, 19*27* that I last saw her alive on *April 8*, 19*27*, and that death occurred, on the date stated above, at *6.00 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

4th Cancer of Stomach
(duration) *1* yrs. mos. da.

CONTRIBUTORY (SECONDARY) *46*
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH..... DATE OF *Apr. 6 - 1926*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *operation*
(Signed) *R. P. Hubig*, M. D.

4/9, 19*27* (Address) *5817 Kearns St. St. Louis*

*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 *Park Lawn* DATE OF BURIAL *4-12 1927*

20. UNDERTAKER *J. Schumacher* ADDRESS *3013 Insurance*

WHITE PAPER, 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.

Dr. Habig
Brewer