

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

Do not use this space.

38210

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *5316 N. Bridge*)

File No.

Registered No. **10831**

St. Ward)

2. FULL NAME *Hedwig Cammann*

(a) Residence. No. *5316 N. Bridge* St., *6* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Max Cammann*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 5 - 1840*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<i>80</i>	<i>6</i>	<i>27</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

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

10. NAME OF FATHER *Enter name*

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

12. MAIDEN NAME OF MOTHER *not known*

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

14. INFORMANT *Mrs. Johanna Reilly*
 (Address) *5316 N. Bridge Road*

15. REG. - 1 1027 *Max C. Starckoff*
 REGISTRAR

3. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 2* 19 *27*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 25* 19 *27*, to *Dec 2* 19 *27* that I last saw him alive on *Dec 2* 19 *27*, and that death occurred, on the date stated above, at *3 47* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

mania
131
99
132 (duration) yrs. mos. *3* ds.
 CONTRIBUTORY (SECONDARY) *Chronic nephritis; arteriosclerosis*
 (duration) *2* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *129 W*
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? *Laboratory*
 (Signed) *Arthur S. Sells, M.D.*

143 19 *27* (Address) *2202 University St*

*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 *Calhoun Cem* DATE OF BURIAL *12/5* 19 *27*

20. UNDERTAKER *Thos J Finnan* ADDRESS *1519 S 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.

