

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

Do not use this space.

28612

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **Stella** (No. **City Hospital**)

File No.
Registered No. **8061**
St. Ward)

2. FULL NAME

(a) Residence. No. **4712 Newbury St.** **12** Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **17** 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)

Separated

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 6 - 1899

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>29</i>	<i>5</i>	<i>0</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)

(STATE OR COUNTRY) *Kentucky*

10. NAME OF FATHER

John Rose

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Indiana*

12. MAIDEN NAME OF MOTHER

Lena Burkhardt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

14.

INFORMANT

(Address)

City Hospital

15.

FILED

Aug 3 1923

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 6 1928*

17. I HEREBY CERTIFY That I attended deceased from *Aug 3 1928* to *Aug 6 1928* that I last saw *alive on Aug 6 1928*, and that death occurred, on the date stated above, at *Aug 12 1928* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*cholera infantis -
312 salvarsan*

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? *Refused*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *Edward Melting, M.D.*
8/6 28 (Address) *City Hospital*

*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

Concordia Cem.

8-9 1928

20. UNDERTAKER

ADDRESS

Wm Brod & U.G. 2929 Jefferson Av.

Kodumkauer

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 8061
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME

Stella Rodenhauer

(a) Residence. No. _____ St. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) sep

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

PARENTS

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED _____ 19 max B. Starkey REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 6 19 28

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cholera
Septic information given over telephone by Dr. Edgar J. Helberg, M.D.
 CONTRIBUTORY (SECONDARY) Septic (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 , 19 (Address) _____

*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 _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-28612