

JAN 28 1929

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City St. Louis

Registration District No. 1123
Primary Registration District No. 6248 C
(No. 828 Regina Ave)

File No. 42427
Registered No. 489
St. _____ Ward _____

2. FULL NAME

Anna Werner
(a) Residence No. 828 Regina Ave 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. cs. 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 OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 28-1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
39 3 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(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) Illinois

10. NAME OF FATHER Bernard Pohlman

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

12. MAIDEN NAME OF MOTHER Mary Linder

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

14. INFORMANT Mrs. Werner
(Address) 828 Regina Ave

15. FILED Dec 28 1928 L. C. Abrody, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 25 1928

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1927, to Dec 25 1928
that I last saw her alive on Dec 25 1928 and that death occurred, on the date stated above, at 6:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
31 1/2 to 13 (duration) yrs. 7 mos. ds.
CONTRIBUTORY Chronic Bronchitis
(SECONDARY) (duration) 1 yrs. 0 mos. 24 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 828 Regina Ave

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Sputum Test
(Signed) John B. Wedge M.D.
, 19 6419 Virginia Ave (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 Mount Olive DATE OF BURIAL 12-29 1928

20. UNDERTAKER Southern U. Co. S. Bradley ADDRESS 7315

WRITE PLAINLY, WITH OUTFRONT MARKING. 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.

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