

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

Do not use this space.

5498

85

MAR 21 1929

1. PLACE OF DEATH

County Bushanan Registration District No. 1001 File No. 160
 Township St Joseph Primary Registration District No. State Hospital #2 Registered No. 160
 City St Joseph (No. State Hospital #2 St. 160 Ward)

2. FULL NAME

(a) Residence. No. State Hosp #2 St. 2 Ward. 2
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 43 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) unknown

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77

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) Europe
 (STATE OR COUNTRY)

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT State Hospital #2
 (Address) State Hospital #2

15. FILED 1929 REGISTRAR John G. [Signature]

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 6 1929

17. I HEREBY CERTIFY That I attended deceased from Jan 15 1929 to Feb 6 1929 and that I last saw h. alive on Feb 5 1929, and that death occurred, on the date stated above, at 12:15 P.M.

73C THE CAUSE OF DEATH* WAS AS FOLLOWS:
15B Chronic Myocarditis

unknown (duration) yrs. mos. ds.
 CONTRIBUTORY Facial Erysipelas
 (SECONDARY) (duration) yrs. mos. ds. 14

18. WHERE WAS DISEASE CONTRACTED? unknown
 IF NOT AT PLACE OF BIRTH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF no
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) Ed Berende, M. D.

2/9 1929 (Address) St Joseph, Mo
 *State the DISEASE CAUSING DEATH or its origin from VENTILATION, USE, etc. (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL State Hospital cemetery DATE OF BURIAL Feb 9 1929

20. UNDERTAKER E.R. Siderfaden 602 South 10th Street ADDRESS

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 63
 51
 51

