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

Do not use this space.

7736

1. PLACE OF DEATH

County St Charles — Registration District No. 757 — File No.

Township — Primary Registration District No. 5998 — Registered No. 28

City — (No. Emmaus Asylum St. 4 Ward)

2. FULL NAME Anna Stensell

(a) Residence. No. Emmaus Asylum St., 4 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U.S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 10 - 1865

7. AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
64	—	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid at Hospital Emmaus

(b) General nature of industry, business, or establishment in which employed (or employer) for 21 years

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Clair Co. Ill.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Jacob Stadler

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

12. MAIDEN NAME OF MOTHER D. Bau

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

14. INFORMANT Jacob Stadler
(Address) Carlinville Ill.

15. FILED 2/16, 1929 Hy G Bloebaum REGISTRAR
Ea

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 — 1929

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to Feb. 15th, 1929, that I last saw her alive on Feb. 15th, 1929, and that death occurred, on the date stated above, at 10 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

83 Terminal Pneumonia
111B
34 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Dementia Paralytica
(duration) 5 yrs. + mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Signs & Symptoms

(Signed) A Erich Schulz, M. D

Feb. 15th, 1929 (Address) St Charles Mo.

*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
Carlinville Ill.	2/18 — 1929.
20. UNDERTAKER: Steinbrinker Fum Co	ADDRESS St Charles Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St. Charles — Registration District No. 757 — File No.
Township " " — Primary Registration District No. 3998 — Registered No. 28
City (No. , St. Ward)

2. FULL NAME Anna Stensell

(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
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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 2/16, 19 29 Hy. G. Bloebaum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1929

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, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Terminal Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Dementia Paralytica
Syphilis ?
(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) W. Arnold Sohn 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

S-7736