

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

Do not use this space.

19478

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **4500**) **Washington** St. _____ Ward _____

File No. _____
 Registered No. **5069**
 St. _____ Ward _____

2. FULL NAME

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

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>March 9 - 1852</i>		
7. AGE	YEARS	MONTHS
	<i>77</i>	<i>1</i>
		DAYS
		<i>22</i>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <i>Homework</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 3 1929*

17. I HEREBY CERTIFY, That I attended deceased from *April 29* 19*29*, to *May 1* 19*29*, that I last saw h. or alive on *April 30* 19*29*, and that death occurred, on the date stated above, at *9:20 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Cardiac Dilatation

50
9:50 P.

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Carcinoma, Breast*

(duration) yrs. mos. ds.

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

10. NAME OF FATHER *unknown*

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

12. MAIDEN NAME OF MOTHER _____

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

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ AND DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Henry J. Ulrich* M. D.
4, 3, 1929. (Address) *64125th Lu Ave*

*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.

14. INFORMANT *Dr. Alvina Scheid*
 (Address) *4500 Washington Blvd.*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Peters Cemetery* DATE OF BURIAL *May 4 1929*

15. FILED *1929*
1929
 REGISTRAR *Max C. Stanley*

20. UNDERTAKER *Wm. Schumacher* ADDRESS *4834 Nat Bridge*

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

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.

RESERVED FOR FUTURE USE

