

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

Do not use this space.

20285

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis. (No. 4248 So. 37 Street. St. Ward)

File No.
 Registered No. 5969

2. FULL NAME

Mary Katherine Deimann.
 (a) Residence. No. 4248 So 37 Street. St. 15 Ward. (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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed.**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb. 22, 1845.**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
84 3 8

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) **Germany.**

10. NAME OF FATHER **Dont Know,**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Dont Know.**

12. MAIDEN NAME OF MOTHER **Dont Know.**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Dont Know.**

14. INFORMANT John G Deimann
 (Address) 4248 So 37 Street.

15. FILED MAY 31 1929 Max C. Stankoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/30/29

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1928 to May 26/1929 that I last saw h. alive on May 24/1929, and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93c
97 (duration) yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY) arterio sclerosis (duration) 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 BY (Signed) B. H. Baker, M. D.

5/31/29 (Address) 3753 Meramec 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Florissant Mo. Sacred Heart Cemetery** DATE OF BURIAL **June 3 19 29**

20. UNDERTAKER **J. V. Gebken & Co.** ADDRESS **2842 Meramec**

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.

