

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

Do not use this space.

22875

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. mo. Bapt Hosp.)

File No.....
 Registered No. 6295
 St. Ward

2. FULL NAME Catharine Wischmeyer

(a) Residence. No. 6216 Page Ave St. 127 Ward. St. Louis Co. mo.
 (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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widowed
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 28, 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 5 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Geo. Schenck

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

12. MAIDEN NAME OF MOTHER Julia ?

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

14. INFORMANT Mr. M. A. Wischmeyer
 (Address) 6216 Page Ave

15. FILED 11/11 7:19 1929 W. C. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1929

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to June 10, 1929.
 that I last saw her alive on June 9, 1929, and that death occurred, on the date stated above, at 4:05 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus

5793A (duration) 1 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Mycocarditis (acute)
 (duration) yrs. mos. 2 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? Clinical
 (Signed) Chester A. Poe M. D.

June 10, 1929 (Address) 6123 Easton 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 Zions Cemetery **DATE OF BURIAL** 6-11 1929
20. UNDERTAKER Geo. L. Pleitsch **ADDRESS** 5966 Easton

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 FAIRLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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