

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

Do not use this space.

12202

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo.** (No. **Lutheran Hospital**)

File No.....
Registered No. **3464**
.....St.Ward)

2. FULL NAME Alvina Platzer

(a) Residence. No. **4936 Tyrolean** St. **2** 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **February 22 1883**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
48 0 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housewife 235**
(b) General nature of industry, business, or establishment in which employed (or employer) **At Home 126 1811**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo.**
(STATE OR COUNTRY)

10. NAME OF FATHER **Joseph Buehler**

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

12. MAIDEN NAME OF MOTHER **Katherine Zeller**

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

14. INFORMANT **William Platzer**
(Address) **4936 Tyrolean**

15. FILED **21 1919** **May C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 18th 1931**

17. I HEREBY CERTIFY, That I attended deceased from **3-8** 19**31** to **3-18** 19**31**.
that I last saw h. **Ex** alive on **3-18** 19**31**, and that death occurred, on the date stated above, at **11:15 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Large Gall Stones (Removal of Gall Stones and gall bladder)
Chronic effectted and infected gall bladder (duration) **8** yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Chronic effectted and infected gall bladder** (duration) **8** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **3-16-31**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & Lab**
(Signed) **L. F. McHenry** M. D.

719, 19**31** (Address) **1831-8-9-31**

*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 **St. Louis Burial Park** DATE OF BURIAL **March 21 1931**

20. UNDERTAKER **Thacker Stelders** ADDRESS **2331 S. Bldg**

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.

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