

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

Do not use this space.

23316

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1008**

City *St Louis Mo* (No. *1452* *College Ave*)

File No.....

Registered No. **6781**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No.....

St. *9*

Ward. *1*

(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

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

*Nov 7<sup>th</sup> 1869*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .....hrs. or .....min.

*61*

*7*

*13*

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 11*

10. NAME OF FATHER.....

*Not known*

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....

(STATE OR COUNTRY)

*Germany*

12. MAIDEN NAME OF MOTHER.....

*Not known*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....

(STATE OR COUNTRY)

*Germany*

14.

INFORMANT.....

(Address)

*Fred. L. Angelbeck*

*1452 College Ave*

15.

FILED

JUN 22 1931

19

*Max E. Stankov*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

*June 20 / 1931*

17.

I HEREBY CERTIFY, That I attended deceased from

19..... 19.....

that I last saw him alive on.....

*6/20/31* 19.....

death occurred, on the date stated above, at.....

*5 P m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Apoplexy  
Cerebral Hemorrhage*

92A (duration) yrs. mos. ds. *20 hours*

82A (duration) yrs. mos. ds. *20 hours*

CONTRIBUTORY (SECONDARY) *Hypertension Chr nephritis*

*Endocarditis* (duration) yrs. mos. ds. *3*

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)

*Wes Simpson M. D.*

6/21 1931 (Address) *3729 Gravois 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

DATE OF BURIAL

*Calvary*

*June 23 1931*

20. UNDERTAKER

ADDRESS

*Math Hermann & Son 261 Fair Ave*

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 PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

