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

Do not use this space.

3046

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis, (No. 3235 Dakota Street. St. ..... Ward)

File No. 639

Registered No. .....

2. FULL NAME Josephine Reiss.

(a) Residence. No. 3235 Dakota Street. St., 15 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Reiss.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 21. 1860.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
66	--	26	

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

PARENTS
10. NAME OF FATHER Herman Schellert.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Dont know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont know

14. INFORMANT Frank Reiss
(Address) 3235 Dakota Street.

15. FILED JAN 19 1927 REGISTRAR May C. Starkeoff

MEDICAL CERTIFICATE OF DEATH 1/17

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 17 — 1927.

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5 — 1926 to Jan. 17 — 1927 that I last saw h. S. alive on Jan. 17 — 1927, and that death occurred, on the date stated above, at 10 55 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Causes Breast (Ryan)
50 4 M
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Cachexia
(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 DIAGNOSIS? Microscopical
(Signed) [illegible], M. D
1/17 1927 (Address) 7606 Kirk. Av.

*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 SS. Peter&Paul Cemetery — DATE OF BURIAL Jan. 20 1927

20. UNDERTAKER H. H. Gebken & Son U. Co — ADDRESS 2842 Meramec

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.