

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

Do not use this space.

6157

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

St. Louis (No. *6919* *Michigan Ave*)

File No.

Registered No. **1313**

St.

Ward)

2. FULL NAME

Louisa Reis

(a) Residence. No. St. **1** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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

Martin

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

Dec 5, 1868

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>58</i>	<i>2</i>	<i>0</i>	

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)

St. Louis

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Theodore Lemke

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Theresa Teitshered

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT (Address)

*Emil S. Reiso
6919 Michigan Ave.*

15.

FILED

-7 1927 Max B. Starkeoff

REGISTERED

MEDICAL CERTIFICATE OF DEATH

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

Feb 5 1927

17.

I HEREBY CERTIFY, That I attended deceased from *Jan. 1 - 1926*, to *Feb 5 - 1927*.
that I last saw her alive on *Feb 5 - 1927*, and that death occurred, on the date stated above, at *8:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic paralytic nephritis
121
930 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

Fully healed

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) *Carl Santner*, M. D.

45 - 1927 (Address) *7606 Mich. 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

S.S. Peter Paul *Feb 8 1927*

20. UNDERTAKER

ADDRESS

Hoffmeister W. & Co 781 S. Broadway

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.

