

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

Do not use this space.

34897

1. PLACE OF DEATH

County.....
Township.....
City..... (No.....) St..... Ward.....

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 10041

2. FULL NAME

Bertha M Reincke

(a) Residence. No. 4212 Lafayette St. Ward. 17
(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) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Conrad Reincke

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 10 - 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 11 29

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 employee).....
(c) Name of employer.....

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

10. NAME OF FATHER Wm Kasow

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

12. MAIDEN NAME OF MOTHER Wm Kasow

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

14. INFORMANT Hazel Smith (Address) 4212 Lafayette

15. FILED NOV 10 1927 Registrar Max Ostarkoff

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 9 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7 1927, to Nov. 9 1927, that I last saw h. or alive on Nov. 9 1927, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
Apoplexy (duration) yrs. mos. ds. 5

CONTRIBUTORY (SECONDARY) 74 (duration) yrs. mos. ds.

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..... (Signature) Wm J. Kleber M. D.

(Address) 3834 Shaw 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 Valhalla Cemetery DATE OF BURIAL Nov. 12 1927

20. UNDERTAKER Fred W. Williams ADDRESS 45th Delmar

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.

