

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

Do not use this space.

35396

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003** File No.
 City **St. Louis** (No. **Alexian Bros Hospital** St. **10582** Ward)

2. FULL NAME

August A. Rembold
 (a) Residence. No. **3421^{1/2} E. McLean** St., **16** Ward. (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 Male **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 Minnie Rembold

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8 - 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
 52 | 2 | 16

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Photo Finisher**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Chillicothe Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Minnie Rembold (Address) 3421^{1/2} E. McLean

15. FILED 04 26 1927 mar 6 Starckoff Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 24 1927

17. I HEREBY CERTIFY, That I attended deceased from **15** Nov 24 1927 that I last saw **alive** on **Nov 24**, 19**27** and that death occurred, on the date stated above, at **3:55 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
131
132 B of pneumonia (duration) yrs. mos. da. **4**
CONTRIBUTORY **Chronic Bronchitis** (SECONDARY) **new nephritis** yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **1240 3421 - McLean**
 IF NOT AT PLACE OF DEATH...
0 DID AN OPERATION PRECEDE DEATH? DATE OF...
 WAS THERE AN AUTOPSY? **no**
 WHAT TEST CONFIRMED DIAGNOSIS? **M. P. Rembold**
 (Signed) **M. P. Rembold** H. D.
 (Address) **3844 11/25 1927**

*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 Peter Paul** DATE OF BURIAL **Nov 28 1927**
20. UNDERTAKER **Wacker-Helders** ADDRESS **2331 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.

