

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

Do not use this space.

15084

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo** (No.)

Registered No. **4006** (If nonresident give city or town and State) Ward)

2. FULL NAME

Addie Reitz

(a) Residence. No. **4309 Strodtmann St.** (Usual place of abode) **7** 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 **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 **Henry Reitz**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 4 - 1879**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **48 4 5**

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 employer) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo.** (STATE OR COUNTRY)

10. NAME OF FATHER **Herman Belvrens**

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

12. MAIDEN NAME OF MOTHER **Don't know**

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

14. INFORMANT **Henry Reitz** (Address) **4309 Strodtmann St.**

15. FILED **May 2 1928** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4 16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 9 - 1928**

17. I HEREBY CERTIFY, That I attended deceased from **April 1** 1928, to **April 9** 1928, (that I last saw him alive on **April 9** 1928, and that death occurred, on the date stated above, at **9 - AM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
139A Acute dilatation of heart
93L chronic myocarditis
95B

CONTRIBUTORY (SECONDARY) **Chronic myocarditis**
Operation for non-malignant Ovarian Cyst.

18. WHERE WAS DISEASE CONTRACTED **IF NOT AT PLACE OF DEATH.....**

DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **April 9 - 1928**

WAS THERE AN AUTOPSY? **not**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**

(Signed) **W.M. Wain** M.D. **4-11** 1928 (Address) **413 Wall Bldg**

*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 **Memorial Park** DATE OF BURIAL **April 12 1928**

20. UNDERTAKER **Woy Leidner and Co. A. Market St.** ADDRESS **1417**

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.

