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

Do not use this space.

File No. 22319
Registered No. 6505

1. PLACE OF DEATH
County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St. Louis Mo. (No. ....., Sanitarium ..... St. ..... Ward)

2. FULL NAME Anna Ries

(a) Residence. No. 1330 Arsenal St., 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 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 Michael Ries

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 24. 1878.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	8	26	

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

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Hungary

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Hungary
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Hungary

14. INFORMANT Frank Ries
(Address) 5300 Arsenal

15. FILED JUN 20 1928 Mary C. Barker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/19/28 19

17. I HEREBY CERTIFY, That I attended deceased from 11/15/27, 19..., to 6/19/28, 19..., that I last saw h. alive on 6/19/28, 19..., and that death occurred, on the date stated above, at 12.40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis of the Central Nervous System
54
28
(duration) yrs. 7 mos. 5 ds.

CONTRIBUTORY (SECONDARY) .....
(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? Clinical & Laboratory

(Signed) Frank H. Parker, M. D
6/19/28, 19 (Address) 5300 Arsenal

*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
J. J. Peter & Paul Cem.	6-21 1928
20. UNDERTAKER	ADDRESS
Witt Bros & Co.	2929 S. Jefferson Av.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD