

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 9030B
 City Overland Mo. Overland Hospital

File No. 25001
 Registered No. 287
 St. _____ Ward _____

2. FULL NAME

Jacob Riemenschneider
3312 Calvert Ave.

(a) Residence No. _____ 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 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) Carrie Riemenschneider

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 14, 1876.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 10 17

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

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

10. NAME OF FATHER Don't know

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

12. MAIDEN NAME OF MOTHER Don't know

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

14. DECEASED'S NAME (Address) Mrs. Carrie Riemenschneider
3312 Calvert Ave.

15. FILED 7/31 1928 Wella Gray (M.D.) REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 31, 1928.

17. I HEREBY CERTIFY That I attended deceased from May 31, 1928 to July 31, 1928
 that I last saw him/her alive on July 31, 1928, and that death occurred, on the date stated above, at _____ A.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Lobar Pneumonia

2:15 P.M.
16 1/2 (duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) Automobile accident
Broken ribs & spine
 (duration) yrs. mos. ds.

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

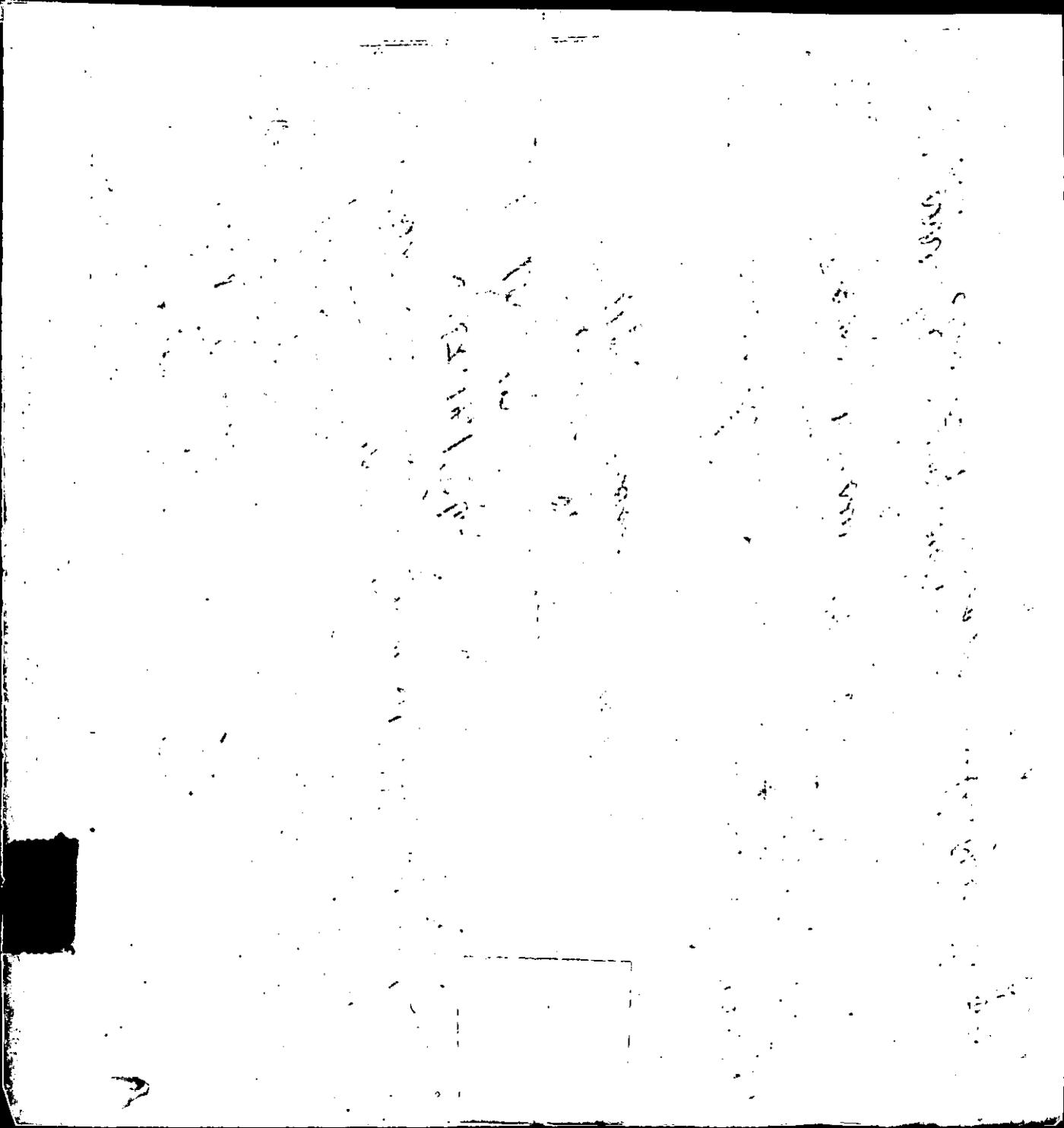
19. DID AN OPERATION PRECEDE DEATH? yes DATE OF 7/30/28
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Stained findings
 (Signed) John Couell, M.D.
July 31, 1928 (Address) Overland mo.

*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.

PLACE OF BURIAL, CREMATION, OR REMOVAL Lake Charles Cem. DATE OF BURIAL Aug. 3, 1928.

28. UNDERTAKER Joe W. Clark ADDRESS 1126 Goddard Ave.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Louis Registration District No. 989 File No. _____
 Township _____ Primary Registration District No. 60330 Registered No. 243
 City Overland (No. _____) St. _____ Ward _____

2. FULL NAME Jacob Remenschneider
 (a) Residence No. _____ St. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
 (write the word)

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 31 1928
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tobacco Pneumonia
 (duration) yrs. mos. ds. _____
 CONTRIBUTORY Automobile accident
 (SECONDARY) St. Louis - St. Charles
 (duration) yrs. mos. ds. _____
 18. WHERE WAS DISEASE CONTRACTED St. Louis - St. Charles Station
 (If not at place of death)
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*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.

14. INFORMANT (Address) _____

15. FILED 9/31 1928 Green Bay, Mo. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

1880

RE COMPLETE AS PRESCRIBED BY LAW

10057-5