

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

Do not use this space.

35101

1. PLACE OF DEATH

County.....*St. Louis*..... Registration District No. **791**
 Township.....*Lutheran Hospital*..... Primary Registration District No. **1003**
 City.....*St. Louis*..... (Name of Hospital)..... St. *10081* Ward.....

2. FULL NAME

(a) Residence. No. *7723 Water St.* St. *1* Ward.....
 (Usual place of abode)

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 *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 *Louise*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 26 1862*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 3 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Painter*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER *Martin Reiter*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Louise Reiter*
 (Address) *7723 Water St.*

15. FILED *OCT 14 1928* *Max B. Starceff*
 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 13th 1928*

17. I HEREBY CERTIFY That I attended deceased from *Sept. 28*, 1928, to *October 13*, 1928 that I last saw him alive on *Oct 12*, 1928, and that death occurred, on the date stated above, at *7:05 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131
91
 Chronic Interstitial Nephritis
 (duration) *Chronic* da.
 CONTRIBUTORY *Arteriosclerosis*
 (SECONDARY) (duration) *Chronic* da.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF

20. WAS THERE AN AUTOPEY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Staining*

(Signed) *Gay L. Ruffin*, M. D.

10/13/1928 (Address) *7723 Water St.*

*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 *Mount Hope* DATE OF BURIAL *10/15 1928*

20. UNDERTAKER *O. Hoffmeyer & Co.* ADDRESS *781 1/2 Perry*

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

