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

Do not use this space.
38397

1. PLACE OF DEATH

County..... Registration District No. 791 1003

Township..... Primary Registration District No.....

City St. Louis (No. City Hosp X St. ..... Ward)

File No.....
Registered No. 11013

2. FULL NAME Ralph H. Mottaz

(a) Residence. No. 5729 Clemens St. 5 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 17 1884

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	44	0	23	

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

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

PARENTS
10. NAME OF FATHER Julius S. Mottaz
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Rosa Wilbanks
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Illinois

14. INFORMANT Viola Mottaz
(Address) 5729 Clemens Av.

15. FILED Nov 11 1928 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 10 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1928, to Nov. 10, 1928 that I last saw him alive on Nov. 10, 1928, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cirrhosis of Liver (Alcoholic)
Ch. Parenchymatous nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1220
(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? Yes
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed) R. Berg, M. D
, 19 (Address) City Hospital

*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
Readsville, Mo	11-12-1928
20. UNDERTAKER	**ADDRESS**
Wagoner	3621 Olive

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

APR 8 1941