

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

Do not use this space.

4527

1. PLACE OF DEATH

County.....
Towship.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **1210**
..... Ward)

2. FULL NAME

(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. 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 26 1863*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 | 1 | 26

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 *At Home*

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

10. NAME OF FATHER *Hy Rose*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mother* (Address) *800 4th Allen Ave*

15. FILED *Jan 24 1929* *Wm C Stankoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 22 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 13* 1928, to *Jan 22* 1929 that I last saw him alive on *Jan 21* 1929, and that death occurred, on the date stated above, at *12:30 A.M.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Endocarditis
93.63
90A1070
CONTRIBUTORY *Broncho Pneumonia* (SECONDARY) (duration) yrs. mos. *4* da.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *For W Relling*, M. D.

1/24 1929 (Address) *2125 Sidney 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 DATE OF BURIAL

St. Peter & Paul Church *Jan 25 1929*

28. UNDERTAKER ADDRESS

Wm J. Robert *4905 S Grand Blvd*

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

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.

235
10
10
10

22