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

Do not use this space.

23027

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

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

File No. .....

Registered No. 6456

2. FULL NAME Rose Weiss

(a) Residence. No: 759 Leland St., 12 Ward. St. Louis Co. Mo

(Usual place of abode) univ. city (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)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 10. 1892

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
37	2	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Max Weiss

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

12. MAIDEN NAME OF MOTHER Sarah Goldfelder

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

14. INFORMANT Mrs. B. C. Brosonde

(Address) Milwaukee Wis.

15. FILED JUN 16 1929, 19 Max C. Faskley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-15-1929

17. I HEREBY CERTIFY, That I attended deceased from 5-25, 1929, to 6-15, 1929 that I last saw her alive on 6-15-29, and that death occurred, on the date stated above, at 6:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Subacute Bacterial Endocarditis

95C

91A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Rheumatic Heart Disease Chronic (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Charles W. Judson, M. D.

, 19 (Address) Barnes 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
Beth-Ham-Hoge	6/17 1929

20. UNDERTAKER	ADDRESS
H. B. Berger	4715 McPherson

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

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