

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

Do not use this space.

35507

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Jewish Home** St. Ward)

File No.
Registered No. **10257**
St. Ward)

2. FULL NAME

(a) Residence No. **5733 Kingsbury St.** **5** Ward. (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) **divorced**

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Israel Grollnek**

7. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 15, 1866**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 0 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **at home**
(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) **Austria**

10. NAME OF FATHER **Mayer Reinfeld**

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

12. MAIDEN NAME OF MOTHER **Amelia Rittersfeld**

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

14. INFORMANT **Mrs. A. Manheimer** (Address) **5733 Kingsbury**

15. FILED **OCT 19 1929** **May C. Harkness** REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 18 19 29**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 10** 19**29**, to **Oct 18** 19**29**, and that I last saw him alive on **Oct 18** 19**29**, and that death occurred, on the date stated above, at **1:35** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
19 (duration) **2** yrs. mos. da.
Diabetes mellitus
(SECONDARY) (duration) **5** yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Albert E. Tamm**, M. D.

10/19 1929 (Address) **3720 Washington**

*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

Mt. Olive Neb **10/21 1929**

20. UNDERTAKER ADDRESS **H. B. Berger** **415 Madison**

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