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

Do not use this space.

38640

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 11044

City St. Louis Mo. (No. ....., Sanitarium St. ..... Ward)

2. FULL NAME Laura Rider

(a) Residence. No. 3970 Shaw Ave. 13 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15. 1858.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	71	4	27	

8. OCCUPATION OF DECEASED

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

(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) Illinois

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Joseph H. Kohler (Address) 5300 Arsenal

15. FILED NOV 12 1929 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/11/29 19

17. I HEREBY CERTIFY, That I attended deceased from 10/14/29, 19..., to 11/11/29, 19..., that I last saw her alive on 11/11/29, 19..., and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic parenchymatous nephritis 131

129a

(duration) ..... yrs. ..... mos. 29 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis

(duration) ..... yrs. ..... mos. 29 ds.

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? Clinical

(Signed) Joseph H. Kohler, M. D.

11/11/29 19 (Address) 5300 Arsenal

*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
New St Marcus Cem.	Nov 13 1929

20. UNDERTAKER	ADDRESS
E. J. Schmur 3125	Lafayette Av.

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.