

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

Do not use this space.

39152

1. PLACE OF DEATH

County Registration District No. 4790T
 Township Primary Registration District No. 0002
 City St. Louis (No. 2009A) Pestalozzi St. _____ Ward)

File No. _____
 Registered No. 11635

2. FULL NAME

Rosalie Jud.
 (a) Residence. No. 2009A Pestalozzi St. 24 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jacob F. Jud.
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 23 1850
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 1 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) Germany
 10. NAME OF FATHER Jos. Rimmermann
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Brigitte Hug
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

14. INFORMANT Anna Jud.
 (Address) 2009A Pestalozzi St.

15. FILED Nov 28 1929 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 26 1929
 17. HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov 26, 1929, that I last saw him alive on Nov 26, 1929, and that death occurred, on the date stated above, at 4:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Strangled umbilical hernia
12 1/2 (duration) yrs. mos. 7 ds.
 CONTRIBUTORY (SECONDARY) 1180W (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? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) Chas E F Smicher M. D.
11/28, 1929 (Address) 8860 S Ramsey

*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 Mo. Crematory DATE OF BURIAL 11-29 1929

20. UNDERTAKER Witt Bros. R + H Co. 2929 S Jefferson ADDRESS _____

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.

PERMANENT RECORD

PARENTS

285

10

REGISTRAR

