

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

Do not use this space.

6539

1. PLACE OF DEATH

County Registration District No. 79
Township Primary Registration District No.
City ST LOUIS (No.) St. (Ward)

File No.
Registered No. 1354

2. FULL NAME

ROSA WIESLER
(a) Residence No. 4027 N 20th St. 26 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 <u>FEMALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>MARRIED</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>MARCH 13th 1883</u>		
7. AGE YEARS <u>46</u>	MONTHS <u>10</u>	DAYS <u>25</u>
IF LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>HOUSE WIFE</u> (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 HUNGARIA

PARENTS	10. NAME OF FATHER <u>LAWRENCE HOFFMANN</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>AUSTRIA HOFFMANN</u>
	12. MAIDEN NAME OF MOTHER <u>KATHARINA GIRTH</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>AUSTRIA HUNGARIA</u>

14. INFORMANT IRAJEYAN WIESLER
(Address) 4027 N 20th

15. FILED 9 1930 Max E. Stodery REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to February 7, 1930, that I last saw her alive on Feb 7, 1930, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
1930 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 9013 (duration) yrs. mos. ds.

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

18 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Wm. Rangan Sr., M. D.
2-8 1930 (Address) 2806 Grand Ave

*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 Calvary Cemetery DATE OF BURIAL Feb 11th 1930

20. UNDERTAKER Edward Koch ADDRESS 3516 1/2 14th

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.

14 235

Dr. Langen
3-6 P.M.
Room 210