

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1005
City St. Louis (No. 1846 S 14 St)

File No. 6842
Registered No. 1679
St. _____ Ward _____

2. FULL NAME

Rose Rathour
(a) Residence. No. 1846 S. 14 St. St. 23 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. da. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 28 - 05
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 16
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Switch Board Operator
(b) General nature of industry, business, or establishment in which employed (or employer) Hotel
(c) Name of employer Sales West Hotel

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bohemia
10. NAME OF FATHER William Rathour
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Bohemia
12. MAIDEN NAME OF MOTHER Albina Simeck
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Bohemia

14. INFORMANT Albina Rathour
(Address) 1846 S 14 St
15. FILED FEB 17 1930 REGISTRAR W. E. Starker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 14 1930
17. I HEREBY CERTIFY, That I attended deceased from 2/3, 1930, to 2/13, 1930, that I last saw him alive on 2/13, 1930, and that death occurred, on the date stated above, at 1 a. m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
(duration) yrs. 6 mos. ds. _____
CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis
(duration) yrs. 1 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) Albert F. Bina M. D.
2/14, 1930 (Address) 1120 Lafayette Ave
*State the DISEASE CAUSING DEATH, or in death from VOLUNTARY CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Peter & Paul DATE OF BURIAL Feb 17 1930
20. UNDERTAKER W. E. Maydell ADDRESS 1926 Allen

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.

