

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

Do not use this space.

10420

**1. PLACE OF DEATH**

County.....  
Township.....  
City St Louis Mo (No. 6244, Foraythe Blvd.)

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 2402  
St. .... Ward

**2. FULL NAME** Bertha Feinberg Rice.

(a) Residence. No. Milwaukee Wisc. St. 5 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) wid.

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

Henry Rice

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
64 7 28

**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) New York City  
(STATE OR COUNTRY)

10. NAME OF FATHER Robert Feinberg

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

12. MAIDEN NAME OF MOTHER Kate Steenbach

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

14. INFORMANT Mrs Edwin Meisner  
(Address) 6244 Foraythe Blvd.

15. FILED 16 19 1930 W. C. Staller REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mich 7 19 30

17. I HEREBY CERTIFY, That I attended deceased from Dec 1922 to Mich 7 1930 that I last saw her alive on Mich 3 1930, and that death occurred, on the date stated above, at 10 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Myocarditis Chr  
59  
936

(duration) 3 yrs. mos. ds.  
CONTRIBUTORY Diabetes mellitus  
(SECONDARY) (duration) 10 yrs. mos. 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?  
(Signed) W. H. Ohlstedt M. D.  
, 19 30 (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 Milwaukee Wis. DATE OF BURIAL 3/10/30

20. UNDERTAKER Mayer ADDRESS - 4356 Lindell.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

2  
2  
10

1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962