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

Do not use this space.

17342

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 4392

City Louis (No. Deaconess Hospital St. ..... Ward)

2. FULL NAME Amelia Reiff

(a) Residence. No. Herman, Mo St. 11 Ward. Herman Mo
(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	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 John Reiff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 6 - 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	63	1	26	

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) Gasconade Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not known

14. INFORMANT John Reiff
(Address) Herman Mo

15. FILED ....., 19 Max C Hartley REGISTRAR

MEDICAL CERTIFICATE OF DEATH 4

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-2- 1930

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to May 2 1930 that I last saw her alive on May 2 1930 and that death occurred, on the date stated above, at 10 30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
Right Side Operation for a Benign Fibroid Tumor of Uterus
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Post Operate Pneumonia
(duration) 54 yrs. 108 mos. 109 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 4128 West Bell Rd
DID AN OPERATION PRECEDE DEATH? Yes DATE April 28
WAS THERE AN AUTOPSY? —
WHAT TEST CONFIRMED DIAGNOSIS? Physical & Clinical
(Signed) Jim J Smith M.D.
5/2, 1930 (Address) 3624 S O Bay

*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
Herman, Mo	May 2 1930

20. UNDERTAKER	ADDRESS
A Kron L Co	2707 N. Grand

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.