

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

Do not use this space.

21122

~~2002~~

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **5232**)

**Thrush Ave**

File No. ....

Registered No. **5976**

St. .... Ward

**2. FULL NAME**

(a) Residence No. **5232 Thrush Ave** St. **7** 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)**

*Single*

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

*June 18, 1930*

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, *12* hrs. or *45* min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....

*None*

(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)

*St. Louis Mo*

**10. NAME OF FATHER**

*John Reale*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*St. Louis Mo*

**12. MAIDEN NAME OF MOTHER**

*Dorothy Scherman*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Jouisville Ky*

**14.**

INFORMANT

(Address)

*John Reale  
5232 Thrush Ave*

**15.**

FILED

1930

19

19

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REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*June 19 1930*

**17.**

I HEREBY CERTIFY, That I attended deceased from.....

....., 19....., to....., 19.....

that I last saw h..... alive on....., 19....., and that

death occurred, on the date stated above, at..... *9:30 A. m.*

**157c** THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Failure of closure of Foramen  
Oval of Heart*

(duration) yrs. mos. *1* ds.

**CONTRIBUTORY (SECONDARY)**

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**19** DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*

(Signed) *Rudolph N. Abel* M. D.

, 19 (Address) *4929 Union Blvd*

\*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

*Friedens*

*June 19, 1930*

**20. UNDERTAKER**

ADDRESS

*Math. Hermann and Son  
216 E. Fair Cor.*

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.

