

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

Do not use this space.

**31294**

**1. PLACE OF DEATH**

County..... Registration District No. 782  
Township..... Primary Registration District No. 1042  
City St. Louis (No. 4963 Robert ar)

File No.....  
Registered No. 8801  
St. .... Ward)

**2. FULL NAME**

Barbara Renisch  
(a) Residence. No. 4963 Robert St., 2 Ward.

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U.S., if of foreign birth? 60 yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Renisch

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 4 - 45

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
84 | 9 | 6

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House wife  
(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) Bohemia

10. NAME OF FATHER Joseph Hruby

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

12. MAIDEN NAME OF MOTHER Anton

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

14. INFORMANT (Address) William Renisch  
4963 Robert

15. SEP FILED 1930 REGISTRAR W. H. Stark

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 10 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Sept 10, 1930, that I last saw her alive on Sept 9, 1930, and that death occurred, on the date stated above, at 5:40 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral hemorrhage (apoplexy)

CONTRIBUTORY (SECONDARY) Chronic myocarditis (duration) 4 yrs. 4 mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED at place of death  
IF NOT AT PLACE OF DEATH, no

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms

(Signed) W. H. Stark, M. D.  
4/12, 1930 (Address) 1544 So. Broadway

\*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 St. Peter & Paul DATE OF BURIAL Sept 13 1930

20. UNDERTAKER W. H. Stark 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.

