

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

Do not use this space.

34116

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1007**
 City **St. Louis** in **3216th North 11th** St. **26** Ward)

File No.....
 Registered No. **9429**
 St. Ward)

2. FULL NAME

Drene B. Herbst
 (a) Residence No. **3216th North 11th** St., **26** Ward.

(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 Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Apr. 28, 1910**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	20	5	3	

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) **St. Louis**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Charles Herbst**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **St. Louis**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Ella Riley**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
 (STATE OR COUNTRY)

14. INFORMANT **Wm. Ella K. Herbst**
 (Address) **3216th North 11th Street**

15. FILED **Wm. C. Starkey** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 1 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 2**, 1930, to **Oct 1**, 1930 that I last saw her alive on **Oct 1**, 1930, and that death occurred, on the date stated above, at **5:20 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Endocarditis

PLE
with (duration) yrs. mos. ds.

CONTRIBUTORY **acute Rheumatic Fever**
 (SECONDARY) **with leptemicia** (duration) 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) **Ralph Thompson**, M. D.
 , 19 (Address) **3624 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 **Calvary** DATE OF BURIAL **Oct 4 1930**

20. UNDERTAKER **Mat. Hermann & Son** ADDRESS **2161st Fair Ave.**

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.

