

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City *St. Louis Mo.* (No. *City Sanitarium*) St. .... Ward (.....)

**34534**

File No.....  
 Registered No. **9910**  
 St. .... Ward (.....)

**2. FULL NAME**

*Mathilda Dreger*  
 (a) Residence. No. *2706 So. 59th* St., *13* Ward. (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred *34 yrs. +* mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 17* 19*30*

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

17. I HEREBY CERTIFY, That I attended deceased from *June 2*, 19*30*, to *Oct 17*, 19*30*. that I last saw her alive on *Oct 16*, 19*30*, and that death occurred, on the date stated above, at *7:45* a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 30. 1866*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>64</i>	<i>8</i>	<i>17</i>	

*Arteriosclerosis*  
 (duration) - yrs. *4* mos. *16* ds. +

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work..... *Unknown*  
 (b) General nature of industry, business, or establishment in which employed (or employer)..... "  
 (c) Name of employer..... "

CONTRIBUTORY (SECONDARY) *Myocarditis (Chronic)*  
 (duration) - yrs. *4* mos. *16* ds. +

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Sweden*

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH..... *Unknown*

10. NAME OF FATHER *Unknown*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

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

WAS THERE AN AUTOPSY? *No*

12. MAIDEN NAME OF MOTHER *Unknown*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*  
 (Signed) *William T. Gutter* M. D.

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

10/17. 1930 (Address) *5400 Arsenal St.*

14. INFORMANT *William T. Gutter M.D.*  
 (Address) *5400 Arsenal St.*

\*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.

15. FILED *May 6 Starkeoff*  
 19..... REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Mathew Cem* DATE OF BURIAL *10 20 1930*

20. UNDERTAKER *Kriegskawand Co* ADDRESS *4104 Manchester*

