

**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** (No. **3836^a** **Louisiana** **Ward**)

File No. **37923**
 Registered No. **11067**
 St. Ward)

2. FULL NAME

(a) Residence. No. **3836^a Louisiana** St. **16** 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 D	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 Frank P. Reitz		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 17 - 1866		
7. AGE YEARS 64	MONTHS 5	DAYS 4
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) at home (c) Name of employer		

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

PARENTS	10. NAME OF FATHER Carl Ruppachter
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Austria
	12. MAIDEN NAME OF MOTHER Unknown
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Austria

14. INFORMANT **Frank F. Reitz**
 (Address) **3836 Louisiana**

15. FILED **NOV 22 1930** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov. 21 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 19th**, 19**30**, to **Nov. 21**, 19**30**, that I last saw h. **A.** alive on **Nov. 21**, 19**30**, and that death occurred, on the date stated above, at **4:15** p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Bicuspidation
92A
 (duration) **3** yrs. mos. ds.
 CONTRIBUTORY **also severe cerebral**
Hemorrhage (duration) **1** 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? **Examination of an**
 (Signed) **Geo. Steiner**, M. D.
 11/22, 1930 (Address) **3606 Grand**

*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 Cemetery** DATE OF BURIAL **Nov. 24 1930**

20. UNDERTAKER **Hauck & Schmitt** ADDRESS **3737 Grand**

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.

