

**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. **1008**

City **St. Louis Mo** (No. **4228** Shenandoah)

26276

File No. **7393**

Registered No. _____

St. _____ Ward)

2. FULL NAME

Minnie A. Rothchild

(a) Residence, No. **4228** Shenandoah St., **16** 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)

Married

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

Scott Rothchild

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

June 11-1861

7. AGE

YEARS **70**

MONTHS **-**

DAY **20**

If LESS than 1 day,hrs. ormin.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housework**

(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) **Mo**

10. NAME OF FATHER

John Deady

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unknown**

14.

INFORMANT

Scott Rothchild

(Address) **4228 Shenandoah**

15.

FILED

-2 1931

Max C. Barker

REGISTERED

2

MEDICAL CERTIFICATE OF DEATH

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

July 1 1931

17.

I HEREBY CERTIFY, That I attended deceased from **April 7 -** 19**17**, to **July 1 -** 19**21**, that I last saw her alive on **July 1** 19**31**, and that death occurred, on the date stated above, at **4:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

91 Cerebral Arterio-Sclerosis - 87B (duration) **7** yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Cerebral Anoxia - (duration) yrs. **3** mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **8715**

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **Chas. S. Barker, M. D.**

July 2, 1931 (Address) **2634 Shenandoah Ave**

*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

Oak Grove

July 3 1931

20. UNDERTAKER

ADDRESS

Amberstone Trust Co **4234**

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.

STATE OF MISSOURI, WITH UNPAIDING INK—THIS IS A PERMANENT RECORD

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