

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

Do not use this space.

791 26973

1. PLACE OF DEATH

County..... Registration District No..... **1008** File No.....
Township..... Primary Registration District No..... Registered No. **8175**
City *St. Louis* (No. *De Paul Hosp*) St. Ward)

2. FULL NAME

Margaret M. Rinchart
(a) Residence. No. *5909 Page Ave* St. *6* 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Geo. W. Rinchart</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Feb 9, 1892</i>		
7. AGE	YEARS <i>39</i>	MONTHS <i>5</i>
	DAYS <i>15</i>	If LESS than 1 day, hrs. or min.

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) *St. Genevieve Co.*
(STATE OR COUNTRY) *Missouri*

PARENTS
10. NAME OF FATHER *A. Flieg*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*
12. MAIDEN NAME OF MOTHER *Barbara Gauer*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Buffalo New York*

14. INFORMANT *Mrs. Geo. W. Rinchart*
(Address) *5909 Page Ave*

15. JUL 25 1931
FRED. W. WARD, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 24 1931*
17. I HEREBY CERTIFY, That I attended deceased from *7/24/31* to *7/24/31* that I last saw h. alive on *7/24/31*, 19....., and that death occurred, on the date stated above, at *11:45 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Hepatitis
1200 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *1250* (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? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS *Cultures*

(Signed) *Albert M. Roubicek M.D.*

. 19 (Address) *3405 1/2 Main*

*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 *Memorial Park Cem* DATE OF BURIAL *7-27 1931*
20. UNDERTAKER *Geo. L. Pleitner Inc.* ADDRESS *5966 Eastern Ave*

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.

Dr. A. W. Coyle

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