

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

Do not use this space.

29427

1. PLACE OF DEATH

County..... Registration District No. 1218
Township..... Primary Registration District No.
City St. Louis (No. City Hospital)

File No.....
Registered No. 8413
St. Ward)

2. FULL NAME

Oscar Reissig
(a) Residence, No. 2210 St. 4th St., 123 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan. 11 - 1866</u>		
7. AGE	YEARS <u>65</u>	MONTHS <u>6</u>
	DAYS <u>22</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>laborer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>26</u>	
	10. Date deceased last worked at this occupation (month and year).....	11. Total time (years) spent in this occupation..... <u>12-18</u>

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 2nd, 1931
22. I HEREBY CERTIFY, That I attended deceased from July 1st, 1931, to Aug. 2nd, 1931, I last saw him alive on Aug. 2nd, 1931, Death is said to have occurred on the date stated above at 10.30 P.M.
The principal cause of death and related causes of importance were as follows:

Gastric Ulcer
Cholelithiasis
Postoperative bronchopneumonia
Other contributory causes of importance: 1170

Date of onset

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
	13. NAME <u>Unknown</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>
	15. MAIDEN NAME <u>Unknown</u>
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

Name of operation Cholecystectomy Date of 7-26-31
What test confirmed diagnosis? fluoroscope Was there an autopsy? refused

17. INFORMANT (ADDRESS) <u>Hospital</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>No. Crematory</u> DATE <u>Aug 5, 1931</u>
19. UNDERTAKER (ADDRESS) <u>Wm. E. J. ...</u>
20. FILED <u>AUG 3 1931</u>

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....
24. Was disease or injury in any way related to occupation of deceased? no
If so, specify no
(Signed) J. E. Scherman, M. D.
(Address) City Hospital

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Registrar

Erasing