

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

Do not use this space.
 29703
 File No. _____
 Registered No. **8736**
 St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. _____
 Township _____ Primary Registration District No. _____
 City _____ (No. St. Louis, St. Louis)

2. FULL NAME

Anna Gritz
 (a) Residence. No. 5408 S. Broadway St. 15 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Wm Gritz

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 10 1851

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
80. 5 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Honorary
 (b) General nature of industry, business, or establishment in which employed (or employer). Self
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) K. Schell
5408 S Broadway

15. FILED May 2 1931 Max C Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) - Aug 13 1931

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1931, to Aug 13, 1931 that I last saw him alive on Aug 13, 1931, and that death occurred, on the date stated above, at 9:30 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral Hemorrhage
820 92A
25R
 (duration) 82A yrs. 1 ds.
 CONTRIBUTORY (SECONDARY) Arterial Sclerosis, Arteriosclerosis
Hypertrophy of Volvolutum
 (duration) 1 yrs. 1 mos. 1 ds.

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS By Hospital Laboratory
 (Signed) O. Schell, M. D.

(Address) 915 No 1st 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Paul Churchyard DATE OF BURIAL 8-15 1931

20. UNDERTAKER Hoffmeister - Gendler ADDRESS 7128 Michigan

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.

