

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

Do not use this space.

10672

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... St. Louis Primary Registration District No. 1008
 City..... St. Louis (No. 3535 Indiana Ave.) St. _____ Ward)

File No. _____
 Registered No. 2743
 St. _____ Ward)

2. FULL NAME Katherine Rievers

(a) Residence. No. 3535 Indiana St. 24 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 <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>12-11-1863</u>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.	
	<u>68</u>	<u>3</u>	<u>9</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work. <u>Housewife</u>					
(b) General nature of industry, business, or establishment in which employed (or employer). <u>23/10</u>					
(c) Name of employer. <u>11/3</u>					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-20-1932

17. I HEREBY CERTIFY, That I attended deceased from 11/10 to 11/19 1932 that I last saw him alive on 19 1932 and that death occurred, on the date stated above, at 19 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute Delirium of the Heart.

CONTRIBUTOR (SECONDARY) Encephalitis & Chorea (duration) yrs. mos. ds. 2 ds.
after 4 yrs from rheumatism (duration) yrs. mos. ds.

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

10. NAME OF FATHER August Meiler

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

12. MAIDEN NAME OF MOTHER Reinholdson

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

18. WHERE WAS DISEASE CONTRACTED 11/10

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? 8 DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Protzberg, M. D.
 , 19 _____ (Address St. Louis 3094 Jefferson)

*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.

14. INFORMANT Alvin Meiler
 (Address) 3434 Indiana

15. FILED 21 19 32
Max C. Stanley REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New St. Marcus **DATE OF BURIAL** 3/28 1932

20. UNDERTAKER Ziegenfuss Bros. **ADDRESS** 2621 Cherokee

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. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

