

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

Do not use this space.

3899

1. PLACE OF DEATH

County..... Registration District No. *1784*
Township..... Primary Registration District No. *7004*
City *St Louis* (No. *5610*, *Eichelberger*)

File No.....
Registered No. *862*
St. Ward

2. FULL NAME

(a) Residence, No. 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 *Male* 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 *Minnie*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 23, 1870*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 3 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Gardener*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Himself*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis, Mo.*

13. NAME *Gred Breuer*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

15. MAIDEN NAME *Minnie Kosfeld*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Minnie Breuer, 5610 Eichelberger*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Mt. Hope Mausoleum* DATE *1-25-33*

19. UNDERTAKER (ADDRESS) *C. Hoffmeister, 1229 28th St. Broadway*

20. FILED *JAN 24 1933*

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 22, 1933*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 7, 1933*, to *Jan 22, 1933*
Last saw him alive on *Jan 21, 1933* Death is said to have occurred on the date stated above, at *12:30* m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
131
130
131
Other contributory causes of importance:
Chronic Interstitial Nephritis?

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? *no*

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 _____
(Signed) *H. H. Himmelfarb* M. D.
(Address) *6811 1/2 Avon Station Mo.*

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

6811A

7C0034