

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.

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

Do not use this space.

8238
31070

1. PLACE OF DEATH

County..... SEP 13 1934 Registration District No. 791
Township..... 1003
City *St. Louis Mo.* (No. *52309*) *Ever Ave* Primary Registration District No. _____
St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Theresa Rice
(a) Residence, No. *52309* *Ever Ave* St. *6* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF *George Rice* (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 26 - 1887*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
47. 1 18

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housework*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *at home*

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) *Indiana*

13. NAME *Joseph Trozzola*

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

15. MAIDEN NAME *Elizabeth Shoner*

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

17. INFORMANT *Dorothy Finesteen* (ADDRESS) *52309 Ever Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary Cem* DATE *Aug 16 - 1934*

19. UNDERTAKER *Edith E. Ankruster* (ADDRESS) *4224 Manchester Ave*

20. FILED *Aug 16 1934* *J. P. Boredeek* Registrar.

1 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 14 - 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 22*, 19*33*, to *Nov 20*, 19*33*

I last saw him alive on *Nov 20*, 19*33* Death is said

to have occurred on the date stated above, at *8 a. m.*

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

*Myocarditis, chronic
cardiac Decompensation*

Date of onset
1933

Other contributory causes of importance: *ABC*

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) *a. e. f. j. b. m. a.*, M. D.

(Address) *4500 Olive*

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JE 4956 University Blvd. Pitt

For Alfred Goldman

F.O. 5631

P.V. 3492

4500 Olive St

DEC