

APR 9 1935

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

Do not use this space.

10976

## 1. PLACE OF DEATH

County .....

Registration District No. **1008**

File No. ....

Township .....

Primary Registration District No. ....

Registered No. **2605**City *St. Louis Mo* (No. *July Sanitarium*) St. .... Ward)2. FULL NAME *Anna Berenyi (BERENYEI)*(a) Residence, No. *1770 So 6th St* St. *22* Ward. (If nonresident, give city or town and State)Length of residence in city or town where death occurred *25* 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) *widowed*5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *unknown*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 10 1894*7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *60 - 7 9*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. *Housework*10. Date deceased last worked at this occupation (month and year) *about Jan 1934* 11. Total time (years) spent in this occupation12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown Austria*13. NAME *unknown*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown Austria*15. MAIDEN NAME *unknown*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown Austria*17. INFORMANT (ADDRESS) *William T. Reiths M.D. 5400 Arden St.*18. BURIAL, CREMATION, OR REMOVAL PLACE *St Matthews* DATE *March 21 1935*19. UNDERTAKER (ADDRESS) *A. H. M. Laughlin 1631 Mississippi Ave*20. FILED *MAR 20 1935* *J. Beredick* Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3/19/35*, 1922. I HEREBY CERTIFY, That I attended deceased from *6/16/29*, 19, to *3/19/35*, 19I last saw *her* alive on *3/18/35*, 19. Death is saidto have occurred on the date stated above, at *8:40 Am.*

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

*Acute myocarditis caused by fall of*

Date of onset

*3/9/35*

Other contributory causes of importance:

*fracture of left femur intertrochanteric*

Date of onset

*3/7/35*

Name of operation .....

Date of .....

What test confirmed diagnosis? *X-ray* Was there an autopsy? *YES*

23. If death was due to external causes (violence), fill in also the following:

Accident, ~~suicide~~ *homicide?* Date of injury *3/7/35*, 19Where did injury occur? *St. Louis Mo.* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *Caused by fall in room*Nature of injury *of City Sanitarium Accident*24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify .....

(Signed) *William T. Reiths*, M. D.(Address) *5400 Arden St.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

