

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

Do not use this space.

32118

**1. PLACE OF DEATH**

County.....  
Township.....  
City **St. Louis Mo.** (No. ....)

Registration District No. **791**  
**1003**  
Primary Registration District No. ....  
**Bethesda Hospital**

File No. ....  
Registered No. **9163**  
St. .... Ward

**2. FULL NAME**

**Audrey M. Reitz**

(a) Residence, No. .... St. **18** Ward. ....  
(Usual place of abode)

**Granite City Ill.**

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) **Single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug. 30/1928**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**I** **12**

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) **Mitchell Ill.**  
(STATE OR COUNTRY)

10. NAME OF FATHER **Otto Reitz**

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

12. MAIDEN NAME OF MOTHER **Ellen Spink**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis Mo.**  
(STATE OR COUNTRY)

14. INFORMANT **Mrs. E. Reitz**  
(Address) **Mitchell Ill.**

15. FILED **12 1929** **W. C. Stanley** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept. 12 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Sept. 8**, 19**29**, to **Sept. 12**, 19**29**, that I last saw him alive on **Sept. 11**, 19**29**, and that death occurred, on the date stated above, at **120** **2** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Acute Enterocolitis**

**11913** **11313** (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Granite City Ill.**  
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF **no.**  
WAS THERE AN AUTOPSY? **no.**

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) **J. H. Peter White** M. D.

**Sept. 12 1929** (Address) **7500 Olive St. St. Louis**

\*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 **Sunset Hill Cemetery** DATE OF BURIAL **9-13 1929**

20. UNDERTAKER **Granite City Ill.** ADDRESS **Gate Road Granite City Ill.**

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.

