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

Do not use this space.

10512

791

1003

2500

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis Mo (No. ..... 5714 Finkman St. ..... Ward)

2. FULL NAME Rosina Weinbauer

(a) Residence. No. 3640 Iowa Ave St., 2 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
71	0	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer At Home

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

PARENTS

10. NAME OF FATHER Unknown Binz

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Ignatius Weinbauer
(Address) 3640 Iowa Ave

15. FILED ....., 19.... [signature] REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 9 1930

17. I HEREBY CERTIFY, That I attended deceased from 3/9/30 ....., 19...., to 3/9/30 ....., 19...., that I last saw her alive on 3/9/30 ....., 19...., and that death occurred, on the date stated above, at 9 30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage c̄ paralysis & death
(sudden death 20 minutes)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Apoplectic Hemiplegia
Chronic myocarditis for years.
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Died at 5714 Finkman

DID AN OPERATION PRECEDE DEATH? no. DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Sudden Paralysis & death

(Signed) O. C. Pfeifer MD, M. D

3/11/30 19 (Address) 4523 S. Kingsheglen

*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 S. S. Peter & Paul Cemetery | DATE OF BURIAL Mar 12 1930

20. UNDERTAKER Wm J. Robert | ADDRESS 1905 S Grand Blvd

MARGIN RESERVED FOR BINDING

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.

J. S. No. 2.