

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

Do not use this space.

791
1003

18862

1. PLACE OF DEATH

County Registration District No.
Township Primary Registration District No.
City *St. Louis* (No. *St. Luke Hosp.*)

File No.
Registered No. *5375*
St. Ward)

2. FULL NAME

(a) Residence, No. *6031 Westminster* St. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 28* 19*34*

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF *John D. Reichart*

22. I HEREBY CERTIFY, That I attended deceased from *Feb - 6th* 19*34* to *May 28* 19*34*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 23 - 1911*

I last saw her alive on *May 25th* 19*34* Death is said

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
23 - 5

to have occurred on the date stated above, at *7:50* p.m.

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation
146

Uremic convulsions -

chron. glomerular nephritis.

Other contributory causes of importance:
Lipoid nephrosis -
(Type of nephritis)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Denver Colo.*

Name of operation *Hysterectomy* Date of *Feb 17-18*

13. NAME *John Waterworth*

What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

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

15. MAIDEN NAME *Mary Gregorie*

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)

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Denver Colo.*

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

17. INFORMANT (ADDRESS) *John D. Reichart*
6031 Westminster

Manner of injury
Nature of injury

18. BURIAL, CREMATION, OR REMOVAL PLACE *Valhalla Crem.* DATE *5-30-* 19*34*

24. Was disease or injury in any way related to occupation of deceased? *No*

19. UNDERTAKER (ADDRESS) *Dr. Leppow & Sons*
4449 Olive

If so, specify (Signed) *J.P. Gay* M. D.

20. FILED *19 21 19* *J. Brebeck* Registrar.

(Address) *905 Beaumont Bldg.*

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.

JUN 19 1934

Washington
Je 9 39r
After 1 P.m. 5 P.m.

P. 1

#2

DEPARTMENT OF COMMERCE

E. T. McLaugh, M. D.,
Special Agent,
Jefferson City, Mo.

BUREAU OF THE CENSUS

WASHINGTON 18862

5375

St. Louis City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Julia W Reinhart
Who died at Wheeler Hoop on May 28 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 23 Months _____ Days 5

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date-deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) Urmage, Convulsions
Birthplace of father (State or country) Chr y loimular nephrite
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance Pregnancy - 146
Name of operation Hysterotomy Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician J.P. Gay
Address of physician 737 University Club Bldg.
Signature of Registrar G.P. Bredeck 9-14-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McLaugh M.D.

Reg. Dist. No. 791

Primary Reg. Dist. No. 1003

Special-Agent

1934
S-18862