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.

REG'D MAR 14 1938

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

Do not use this space. 4877

Registration District No. 791

Primary Registration District No. 1003

Registered No. 1522

1. PLACE OF DEATH

(a) County

(b) Township

(c) City ST LOUIS MO.

(d) Street No. 2103 E. PRARIE AVE St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME KATIE M. RONGE 520

(a) Residence, No. 2103 E. PRARIE AVE St. 9

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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: BERNARD RONGE

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): APR. 29TH 1860

7. AGE: YEARS 77 | MONTHS 9 | DAYS 11 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: HOUSE WORK

9. Industry or business in which work was done, as 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): ST. LOUIS MO

FATHER

13. NAME: JOHN GLAS

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): GERMANY

MOTHER

15. MAIDEN NAME: CAROLINE BERGER

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): GERMANY

17. INFORMANT (ADDRESS): Clara M. Foerster 2103 E. Prairie Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE: CALVARY DATE: FEB 14TH 1938

19. FUNERAL DIRECTOR (ADDRESS): BROCKLAND UND. CO 1827 HOGAN STR

20. FILED: FEB 12 1938 J. D. Buchek Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): FEB. 10TH 1938

22. I HEREBY CERTIFY, That I attended deceased from Nov 1 1937, to Feb 10 1938

I last saw her alive on Feb 9 1938. Death is said to have occurred on the date stated above, at 11:45 P.m.

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

	Date of onset
Cerebral Hemorrhage	2 days
Other contributory causes of importance:	
Arteri Sclerosis	?

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....

If so, specify .....

(Signed) Seth P. Smith, M. D.

(Address) 4500 Clarence

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, John B. Brockland, Licensed Embalmer No. 93.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed John B. Brockland

Licensed Embalmer No. 93.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)