DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35836

FILED OCT 18 1943

Registration District No. 7 — Primary Registration District No. 3063 — Registrar's No. 2315

1. PLACE OF DEATH:

(a) County: ST. LOUIS,

(b) City or town: CLAYTON, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. LOUIS COUNTY HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 6 WEEKS (Specify whether years, months or days)

In this community: 6 WEEKS

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: ST. LOUIS

(c) City or town: RURAL, (If outside city or town limits, write "RURAL")

(d) Street No.: WILD HORSE CREEK RD. (If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: VIDA N. SONTAG,

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: MARRIED

6. (b) Name of husband or wife: FRED SONTAG,

6. (c) Age of husband or wife if alive: 50 years

7. Birth date of deceased: NOV. (Month) 24 (Day) 1893 (Year)

8. AGE: Years 49 Months 10 Days 27 If less than one day ____ hr. ____ min.

9. Birthplace: ST. LOUIS COUNTY, (City, town, or county) MO. (State or foreign country)

10. Usual occupation: HOUSEWIFE,

11. Industry or business: OWN HOME

FATHER

12. Name: FRED DACHROEDEN,

13. Birthplace: ST. LOUIS COUNTY, (City, town, or county) MO. (State or foreign country)

MOTHER

14. Maiden name: CORNELIA WALTER

15. Birthplace: ST. LOUIS COUNTY, (City, town, or county) MO. (State or foreign country)

16. (a) Informant: FRED SONTAG,

(b) Address: CHESTERFIELD, MO. R-1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: OCT. 14-1943 (Month, day, year)

(c) Place: burial or cremation: ANTIOCH CEM. MO.

18. (a) Signature of funeral director: SCHRADER FUNERAL HOME

(b) Address: BALLWIN, MO.

19. (a) 10-13-43 (Date received by local registrar) (b) C. J. McGarry M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 11, year 1943 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw him alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	10 days.
Due to: Kidney damage	1 month +
Due to: Hypertensive Heart disease	years

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work?

(e) Means of injury:

23. Signature: Eighie Massnagle M.D. (M.D. or other)

Address: 6 S. Hoop Date signed: 10-13-43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 2
2-43
17-39
X35596

09
3/43

767

OCT 18 1949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Theo. Schrader

Licensed Embalmer No. 8066

P. O. Address Galewin, M

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

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. NOV

Registration District No. 319 Primary Registration District No. 3063 Registrar's No. 2315

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Vida N. Santag
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased Nov. 24 1879 (Month) (Day) (Year)

8. AGE: Years 49 Months 10 Days 27 Hours min. (Unless than one day)

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day
year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 8-30-43, 19, to 10-11-43, 19;
that I last saw h alive on, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Due to Kidney damage Chronic	
Due to Hypertension heart disease	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 1 3 1 P
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Leechi Massarella (M.D. or other)
Address St. Louis County Hosp. Date signed 11/1/43

SUPPLEMENTARY

35836