

FILED SEP 30 1944

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5115 Cabanne Avenue
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community **Life** / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5115 Cabanne Avenue**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **DORA LANGE VOSS**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **W**
 6. (b) Name of husband or wife **August Voss** 6. (c) Age of husband or wife if alive **dec.** years
 7. Birth date of deceased **11 3 1867**
(Month) (Day) (Year)

8. AGE: Years **76** Months **10** Days **16**
 If less than one day hr. _____ min. _____

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business _____

MOTHER FATHER
12. Name **Peter Lange**
13. Birthplace **Alsace Lorraine, France**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Pfalzgraf**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Amy Pfalzgraf**
 (b) Address **5115 Cabanne Avenue**

17. (a) Burial (b) Date thereof **9-19-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Alexander + Sons**
 (b) Address **6175 Delmar Boulevard**

19. (a) SEP 20 1944 (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **19th** year **1944** hour **6:50** minute **7** P. M.

21. I hereby certify that I attended the deceased from **Jan 1944** to **Sept 1944**
 and that death occurred on the date and hour stated above. **Sept 19 1944**

Immediate cause of death **Carcinoma of Liver**
 Duration **6 yrs.**

Due to _____
 Due to **H67**
 Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: **None**
 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? _____

While at work? _____ (Specify type of place)
 (c) Means of injury _____

23. Signature **Paul K. Webb** (M. D. or other) _____
 Address **1508 Chemical Bldg.** Date signed **9-20-44**

Dr. P. K. Webb
Medical. Bldg
721 Chest
12th Ward.

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 jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Pullman

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

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