FEB 25 1927

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

Do not use this space.

1554

1. PLACE OF DEATH
County Jefferson
Township Valle
City De Soto Mo
Registration District No. 420
Primary Registration District No. 5574
File No.
Registered No. 1
St. Ward)

2. FULL NAME William Oltrogge
(a) Residence. No. Rt 1 St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 8 1855

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
70	4	26	

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

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

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER ~~Dont Know~~ Sophia Langhorst
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Van Hegen
(STATE OR COUNTRY) Germany Show

14. INFORMANT Henry Oltrogge
(Address) St Louis Mo

15. FILED 1/5 1927 D. L. Rauggly REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1926 to Jan 4, 1927 that I last saw him alive on Jan 4, 1927 and that death occurred, on the date stated above, at 9 30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
131 Chronic Nephritis
930
129
(duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis
(duration) yrs. 7 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings
(Signed) Geo E Fallet, M. D
1/5, 1927 (Address) De Soto Mo

*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 Park Lawn Cemetery St Louis
DATE OF BURIAL Jan 8 1927

20. UNDERTAKER C H Bornhart
ADDRESS De Soto Mo

N. B.—Ev[illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE O[illegible] in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Sophia Langhorst

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Jefferson — Registration District No. 420 — File No. .....
Township: Valley — Primary Registration District No. 5574 — Registered No. 1
City ..... (No. ..... St. ..... Ward)

2. FULL NAME: William Othrogge

(a) Residence. No. ..... St., ... Ward, ... (If nonresident give city or town and State)
(Usual place of abode)
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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 8, 1855

7. AGE: Years 71 — Months 4 — Days 26 — If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 3/25, 1927 — H. L. Rangeley — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 4, 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
....., 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS DO NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-1334