

JAN 28 1929

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

Do not use this space.

42378

1. PLACE OF DEATH

County St. Louis Registration District No. 289 File No.
 Township Central Primary Registration District No. 60330 Registered No. 373
 City (No. 6352, Hobart Ave.) St. Ward)

2. FULL NAME

Mabel Lange
 (a) Residence. No. 6352 Hobart Ave. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 William H. Lange
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. About 50
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri
 10. NAME OF FATHER Wm. Davis
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 12. MAIDEN NAME OF MOTHER Adelia Herndon
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Thonterville Missouri

14. INFORMANT Mr. Wm. H. Lange (Address) 6352 Hobart Ave.
 15. FILED 12/18, 1928 Holla Gray, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15 1928
 17. I HEREBY CERTIFY, That I attended deceased from 8:30 1928, to Dec 15, 1928, that I last saw h. or alive on Dec 15, 1928, and that death occurred, on the date stated above, at 10:30 a.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Polar Pneumonia
11 1/2 (duration) yrs. mos. 8 da.
 CONTRIBUTORY (SECONDARY) grippe (duration) yrs. mos. da.

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) August Maykamp, M. D.
12/19, 1928 (Address) 2313 University Street
 *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 Cem. DATE OF BURIAL 12-18 1928
 20. UNDERTAKER Geo. L. Pleitsch ADDRESS 5466 Easton Ave.

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.

