

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

Do not use this space.

25712

1. PLACE OF DEATH

County St. Louis Registration District No. 189
 Township Central Primary Registration District No. 6033 B
 City (No. Eminence & North Ave. St. Ward)

File No. _____
 Registered No. 224

2. FULL NAME Minnie Rosengarten

(a) Residence. No. Eminence & North Ave 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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 George W. Rosengarten

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 2, 1864

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	64	10	12	

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 F. W. Nolte

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Frederika Krueger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany

14. INFORMANT George W. Rosengarten
 (Address) Eminence & North Ave

15. FILED 7/15 1929 Rolla B. Tracy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 14 1929

17. HEREBY CERTIFY, That I attended deceased from July 4 1929 to July 14 1929
 that I last saw alive on July 13 1929, and that death occurred, on the date stated above, at 5:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

abdominal carcinoma
46 F. (duration) yrs. 4 mos. ds.
 CONTRIBUTORY (SECONDARY) no known
53 F. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF July 13, 29

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Operative & clinical
 (Signed) John D. Pal, M. D.

(Address) 1492 Hodiamon

*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 DATE OF BURIAL

Oak Grove Cem. 7-16 1929

20. UNDERTAKER Geo. L. Kleitsch ADDRESS 5966 Eastern Ave

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**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 St. Louis
Township Central
City..... (No.)

Registration District No. 789
Primary Registration District No. 6033 B

File No.
Registered No. 224
St. Ward)

2. FULL NAME

Minnie Rosenqvist

(a) Residence. No. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	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)

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 7/15 19 29 Rolla Dray M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 14 19 29

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:
Abdominal Carcinoma of Cecum of Colon - Intestines

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

44 B

(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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

STRIPS SHALL NOT RECEIVE A FEE FOR CERTIFICATION. THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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