

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

Do not use this space.

35748

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **T 003**
City **St. Louis** (No. **5720**) **Brought Ave** St. Ward

File No.
Registered No. **10544** St. Ward

2. FULL NAME

(a) Residence. No. **#5720 Brought Ave** Ward **5**
(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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan'y, 8th 1860**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 9 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **at home**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) **Metropolis, Ill.**
(STATE OR COUNTRY)

10. NAME OF FATHER **Hy. Rodenberg**

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

12. MAIDEN NAME OF MOTHER **Ma. the Johnson**

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

14. INFORMANT **Millie Tredenburg**
(Address) **#5720 Brought Ave**

15. FILED **OCT 23 1929** **W. C. Parker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 25th 1929**
17. I HEREBY CERTIFY, That I attended deceased from **Jan'y 28** 19... to **Oct 25** 19... that I last saw him alive on **Oct 22** 19... and that death occurred, on the date stated above, at **1 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral insufficiency

911A (duration) **2** yrs. mos. ds.
CONTRIBUTORY **Hypertension** (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Do not know**
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Kate E. Spain** M. D.
(Address) **5116 Page**

*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 **Altamont, Ill.** DATE OF BURIAL **10-28, 1929**

20. UNDERTAKER **C. R. Rupton** ADDRESS **4419**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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Dr. Kate Sparr
5116 Page ave.
1130 Kt 1.