

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

Do not use this space.

10725

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... (No.....)

Registration District No. **791**  
Primary Registration District No. **1003**

File No.....  
Registered No. **2738**  
St..... Ward)

**2. FULL NAME**

*Baby Lange*

(a) Residence. No. **4046 a 1/2 ave** St., **15** Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. **1** 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) **3-2-1930**

7. AGE YEARS MONTHS DAYS **3** If LESS than 1 day, ..... hrs. or ..... 30 min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St Louis, Mo*  
(STATE OR COUNTRY)

**PARENTS**  
10. NAME OF FATHER *Herbert Lange*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis, Mo.*  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER *Ethel Helen Box*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Francis Count*  
(STATE OR COUNTRY) *Missouri*

14. INFORMANT *Mrs Ethel Lange*  
(Address) *4046 1/2 ave*

15. FILED **18** 19**30** *Miss C. Starck* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 2* 19**30**

17. I HEREBY CERTIFY, That I attended deceased from *March 2* 19**30**, to *March 2* 19**30** that I last saw h. *er* alive on *March 2* 19**30**, and that death occurred, on the date stated above, at *2:15 A.M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Prematurity - 6 months*  
*159* (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *6/1W* (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *Henry C. Westerman* M. D.

*March 3, 1930* (Address) *2136 E. Grand Blvd*

\*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 **PO** DATE OF BURIAL **3-20-1930**

20. UNDERTAKER *E. Shanon, 1426 Carroll* ADDRESS

No. 1. 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.

100-100000

U. S. DEPARTMENT OF JUSTICE

A