

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

Do not use this space.

14638

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *1021 Central Ave*)

File No.....
Registered No. *3359*
St..... Ward)

2. FULL NAME

Sophia Gass
(a) Residence. No. *1021 Central Ave* *4* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *40* 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*

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Valentine Gass*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *4-23-1853*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
96 11 10

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) (STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *Nicholas John*

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

12. MAIDEN NAME OF MOTHER *unknown*

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

14. INFORMANT *Valentine Gass*
(Address) *1021 Central Ave*

15. FILED *APR 23 1930* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-3* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *Mar 21*, 19*29*, to *Apr 3*, 19*30*, that I last saw him/her alive on *Apr 3*, 19*30*, and that death occurred, on the date stated above, at *6 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis (hypertrophic)
myocarditis chronic
12.41A

97C (duration) yrs. mos. da.
97 *Arteriosclerosis*

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

18. WHERE WAS DISEASE CONTRACTED *1021 B1*
IF NOT AT PLACE OF DEATH

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

WHAT TEST CONFIRMED DIAGNOSIS *usual*
(Signed) *E.R. Northrup* M. D.
19 (Address) *Chouteau Trust Bldg.*

*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 *Valhalla Cemetery* DATE OF BURIAL *4-5* 19 *30*

20. UNDERTAKER *Kriegshausen S. King* ADDRESS *4228*

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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STANDARD TELEPHONE & TELEGRAPH COMPANY
NEW YORK, N. Y.

Dr. J. H. Thompson
1022 Clayton's Terrace

NEW YORK, N. Y.
MAY 10 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 5th inst. in relation to the above matter.

The same has been referred to the proper authorities and they are endeavoring to ascertain the facts of the case.

I am, Sir, very respectfully,
Yours truly,
J. H. Thompson