

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

Do not use this space.

20727
20195

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *1003*)

Registration District No. *797*
Primary Registration District No. *1003*

File No.
Registered No. *5520*.
St. Ward)

2. FULL NAME

(a) Residence. No. *4160 Walling Court*, *11* Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Charles J. Sondermann*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 16, 1865*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>64</i>	<i>10</i>	<i>20</i>	

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).
(c) Name of employer.

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

10. NAME OF FATHER *Philip Gull*

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

12. MAIDEN NAME OF MOTHER *Martha Haass*

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

14. INFORMANT *Hazel Sondermann*
(Address) *4160 Walling Court*

15. FILED *1920* *19* *20* *Wald Barker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 5 1930*

17. I HEREBY CERTIFY, That I attended deceased from *May 29 1930*, to *June 5 1930*, that I last saw her alive on *May 5 1930*, and that death occurred, on the date stated above, at *7:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus
Staphylococic infection
right side of face + paralyzed
glaucoma acute unknown yrs. mos. ds.
hypertensive atherosclerosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *115 B*

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *5-30-30*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Bacteriological - Chemical*
(Signed) *Carl H. Lindenmeyer, M. D.*

, 19 (Address) *4176 - Shreve*

*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

Friedens

DATE OF BURIAL

June 9 1930

20. UNDERTAKER

Matth. Hermann, Reg. Lic. 2161 E. Fairborn

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.

