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

Do not use this space.

11123

1. PLACE OF DEATH

County ..... Registration District No. 78 ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 2164

City ..... (No. Christian Hospital St. ..... Ward)

2. FULL NAME Mamie Varwig

(a) Residence. No. 4817 @ Natural Bridge St., 6 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: Rudolph Varwig

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 5. 1886

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
46	4	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(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) Mo.

PARENTS

10. NAME OF FATHER Michael Holley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Elizabeth Heitgraf

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

14. INFORMANT Rudolph Varwig
(Address) 4817 Nat Bridge

15. FILED MAR 03 1933 19 Max C Harley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

No Physician in attendance

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 3, 1933

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 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Interstitial Nephritis
Chronic

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 3

(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? Yes.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Frank P Farling, M.D.

3/4, 1933 (Address) Crooker

*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: Calvary Cemetery

DATE OF BURIAL: 3-6 1933

20. UNDERTAKER: Geo E Mahler 4725 St Louis Av

ADDRESS

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.