

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

Do not use this space.

DEC 12 1935

1. PLACE OF DEATH

County.....
Township.....
City..... **ST LOUIS**

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

File No. **37784**
Registered No. **9760**
St. _____ Ward _____

2. FULL NAME **IDA KULAGE**

(a) Residence. No. **1906 COLLEGE AVE** **9** Ward.

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (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) **SINGLE**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **AUG 14 TH 1859**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **76 3 6**
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **HOUSEWORK Home** (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **GERMANY** (STATE OR COUNTRY)

10. NAME OF FATHER **WILLIAM KULAGE**

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

12. MAIDEN NAME OF MOTHER **MARGARETH WALHERSLOH**

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

14. INFORMANT **MARGARETH FORTCHNEIDER** (Address) **1906 COLLEGE AVE**

15. **NOV 21 1935** **J. F. Briedeck** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov. 20 19 35**

17. I HEREBY CERTIFY, That I attended deceased from **Mar. 27th**, 19**25**, to **Nov 20**, 19**35** that I last saw h. **alive** on **Nov. 19**, 19**35**, and that death occurred, on the date stated above, at **7:30 a. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic myocarditis (duration) **10+** yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) **9 30** yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **930** IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS (Signed) **Albert J. Mozet** M. D. (Address) **2743 910 Grand Bld.**

*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 **Galvary Cemetery** DATE OF BURIAL **Nov 23^d 19 35**

20. UNDERTAKER **Edward Koch** ADDRESS **3516 414th**

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.

