

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.

OCT 5

1936

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **St. Anthony's Hospital**) St. Ward)

35784

File No.
Registered No. **9405**

2. FULL NAME **Joseph Anthony Sondag**

(a) Residence, No. **3709 Connecticut Ave.** **16** 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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 7, 1908		
7. AGE	YEARS	MONTHS
	28	4
		DAYS
		4
	If LESS than 1 day, hrs. or min.	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	Clerk
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	John Deere Plow Co.
	10. Date deceased last worked at this occupation (month and year).....	11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	St. Louis Mo.
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13. NAME	Peter A. Sondag
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14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	St. Louis Mo.
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15. MAIDEN NAME	Emma Stoverink
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16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	Holland
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17. INFORMANT (ADDRESS)	Emma Sondag 3709 Connecticut Ave.
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18. BURIAL, CREMATION, OR REMOVAL PLACE	St. Peter & Paul DATE 9-14 19 36
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19. UNDERTAKER (ADDRESS)	Kriegshauser Mortuaries 4104 Manchester Ave.
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20. FILED	12 10 36 19 St. Bredeck Registrar.
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MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-11** 19**36**22. I HEREBY CERTIFY, That I attended deceased from **8/19** 19**36** to **9/11** 19**36**I last saw him alive on **9/10** 19**36** Death is said to have occurred on the date stated above, at **4 A.M.**

The principal cause of death and related causes of importance were as follows:

Myocardial Failure Date of onset**12/1**

Other contributory causes of importance:

Valvular Heart Disease**Chronic Nephritis**Name of operation..... **None** Date of

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? **No** Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury..... Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No** If so, specify(Signed) **Chas. J. Ingh** M. D.
(Address) **2102 So. Grand Pl.**

Mr. C. O. Metz
2722 Ardenway

La. 0313

4-5-78