

REC'D JUN 12 1939

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

16715

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City..... St. Louis (d) Street No. De Paul Hospital Registered No. **4249** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Sophia Rau**

(a) Residence, No. Florissant, Mo. St. **NR** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 George Rau		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 15, 1866		
7. AGE YEARS 73	MONTHS 2	DAYS 20
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At home	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year).....	11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN)..... St. Louis County (STATE OR COUNTRY) Mo.		
FATHER	13. NAME Chris Warnecke	
14. BIRTHPLACE (CITY OR TOWN)..... Germany (STATE OR COUNTRY)		
MOTHER	15. MAIDEN NAME Rosenia Abel	
16. BIRTHPLACE (CITY OR TOWN)..... Germany (STATE OR COUNTRY)		
17. INFORMANT..... Mrs. Walter Gittge (ADDRESS) Rt. 1 Florissant, Mo.		
18. BURIAL, CREMATION, OR REMOVAL PLACE Black Jack, Mo. DATE May 9, 1939		
19. FUNERAL DIRECTOR (NAME)..... Charles W. ... (ADDRESS) 4911 Washington Bl.		
20. FILED MAY 8 1939 J. P. ... Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 5, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **May 3, 1939**, to **May 5, 1939**
I last saw her alive on **May 5, 1939**. Death is said to have occurred on the date stated above, at **10:20 p. m.**
The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia

Date of onset **Apr. 22**

Other contributory causes of importance:
Toxemia
Chr. Nephritis

Name of operation **none** Date of:

What test confirmed diagnosis? **none** Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **none** Date of injury....., 19.....
Where did injury occur? **none**
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **none**
Nature of injury **none**

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify.....
(Signed) **W. E. Stubble**, M. D.
(Address) **2000 E Grand**

(Licensed Embalmer's Statement on Reverse Side)

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Thomas R. Fenwick

Licensed Embalmer No. *3793*

P. O. Address *St. Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.