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REC'D JUN 12 1939

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

17407
Do not use this space.

791
1003

1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township ..... Primary Registration District No. ..... Registered No. 4941

(c) City St. Louis (d) Street No. St. Louis Children's Hospital 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.

357

2. PRINT FULL NAME Uding, Rosina Louise

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F	W	child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF child

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-18-39

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	—	—	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. child

9. Industry or business in which work was done, as saw mill, bank, etc. Child

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. Geneviève, Mo.

FATHER

13. NAME Val Uding

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER

15. MAIDEN NAME Josephine Figge

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Miss S. Vedder St Louis Childrens Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Ste Geneviève Mo DATE 5-30-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A H Hoppe 4700 Washington

20. FILED MAY 31 1939 J. F. Brelich Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-30-1939

22. I HEREBY CERTIFY, That I attended deceased from 5-24-1939, to 5-30-1939

I last saw her alive on 5-29-1939. Death is said to have occurred on the date stated above, at 12:45 a.m.

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

	Date of onset
Pneumococcus Meningitis	5-22-39

Other contributory causes of importance:

Acute Non-Supparative Bilateral Otitis Media	5-22-39

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Laboratory Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... 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) [signature], M. D.

(Address) 600 So. Kingshighway

(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.

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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 Albert H. Hoppe

Licensed Embalmer No. 1861

P. O. Address_____

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.