

Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **1634**

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (b) City or town **Rural**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **Route 4 Box 72 Baden Sta 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME **Roy Arthur Prange 652**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **August 26th 1940**
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **22** hr. **5** min.

9. Birthplace **St. Louis**
 (City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business **none**

MOTHER FATHER
 12. Name **Arthur J.F. Prange**
 13. Birthplace **Renault, Ill** (State or foreign country)
 14. Maiden name **Lillian or Wartz**
 15. Birthplace **Marrissa, Ill** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Arthur J. Prange**

(b) Address **Route 4 Box 72 Baden Station**

17. (a) **RURAL** (b) Date thereof **Aug 27th, 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Marrissa, Ill**

18. (a) Signature of funeral director **Arthur P. Dick**
8319 Hallsberry Road
 (b) Address

19. (a) **AUG 27 1940** (b) **J.R. Meyer**
 (Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **0 Missouri** (b) County **St. Louis**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Route 4 Box 72 Baden Sta**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **27**
 year **1940** hour **5:45** minute _____ M.

21. I hereby certify that I attended the deceased from **Aug 26**
10:40 19 **40** to **Aug 27** 19 **40**
 that I last saw him alive on **Aug 26** and that death occurred on the date and hour stated above.

Immediate cause of death **Patient foramen Ovale** Duration **1 day**

Due to _____

Due to **15 10**

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **John A. Harris** (M. D. or other) _____
 Address **8229 9 Bohay** Date signed **8/28/40**

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 *Albert G. Hoppa*

Licensed Embalmer No. *2971*

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.