S. No. 2
DM—2-43
5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33464

Registration District No. 318 Primary Registration District No. 1002 Registrar's No. 9327

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL," and name of township)

(c) Name of hospital or institution: St. Louis City Hospital, Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days (Specify whether years, months or days)
In this community 45 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 2002½ CASS AV.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Marie Beatrice Rengstorff

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife WILLIAM RENGSTORFF.

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased MARCH 4TH 1887 (Month) (Day) (Year)

8. AGE: Years 56 Months 7. Days 17. If less than one day — hr. — min.

9. Birthplace CHICAGO ILL. (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business AT HOME

MOTHER FATHER

12. Name WILLIAM PARIDY

13. Birthplace ILL (City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace " " " (City, town, or county) (State or foreign country)

16. (a) Informant William J. Rengstorff

(b) Address 2002½ Cass Ave.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 25-43 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director Brockland Fud Co

(b) Address 1827 Hogan St.

19. (a) OCT 23 1943 (Date received local registrar) (b) J. F. Bardeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21, year 1943 hour 12:00 minute Noon M.

21. I hereby certify that I attended the deceased from October 17, 1943 to October 21, 1943 that I last saw her alive on October 21, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Hepar Lobatum (Syphilitic) — Duration

Due to Chronic Bronchitis and Pulmonary Emphysema

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy as above

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) none

(b) Date of occurrence

(c) 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature William J. Barr (M. D. or other)

Address 1515 Lafayette Avenue Date signed 10/21/43

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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, fact should be so stated above.