

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8179

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3025**

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
1608 N. 17th St.
(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)

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. **1608 N. 17th St.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Anna Roettger**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **4th**
year **1945** hour **9** minute **00A** M.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Fred Roettger**

6. (c) Age of husband or wife if alive **76** years

7. Birth date of deceased **September 25, 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan. 1st-45**
19....., to **March 19** 19.....

that I last saw ~~her~~ alive on **3-19-45** 19.....;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	74	6	9hr.min.

Immediate cause of death
Chronic Myocarditis

Due to **Chronic Industrial nephritis**

Due to.....

Other conditions (Include pregnancy within 3 months of death) **1/31**

9. Birthplace **St. Louis** (City, town, or county) **1** (State or foreign country)

10. Usual occupation **Housework**

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name **William Schmidt**

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

14. Maiden name **Minnie Hofmann**

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

16. (a) Informant **Fred Roettger**

(b) Address **1608 N. 17th St.**

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

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

(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?.....

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **Apr. 6, 1945** (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **Paschedag-Henke Fun. Home**

(b) Address **2825 N. Grand Blvd.**

23. Signature **John J. Nawrocki** (M. D. or other)

Address **1900 Madison St.** Date signed **4-4-45**

19. (a) **APR 4 1945** (Date received local registrar)

J. J. Brueck (Registrar's signature)

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

Robert W. Kaye

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, fact should be so stated above.