

S. No. 2
FORM-2-43
Rev. 5-17-36
X 35597

19226

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 19 1945 318

Primary Registration District No. 1003

Registrar's No. 4934

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD JUN 7 1945

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:
City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0611
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17

(d) Street No. 1633a Tower Grove Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME John Sontag

3. (b) If veteran, name war No

3. (c) Social Security No. 491-14-8248

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1st, year 1945 hour 7:45 minute A. A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Not given 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 11, 1870.
(Month) (Day) (Year)

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid hemorrhage Duration

8. AGE: Years Months Days If less than one day

74 7 20 hr. min.

Subarachnoid hemorrhage of brain & fracture of both legs. When he was struck by automobile being driven by one Harry Appelbaum at the intersection of 18-1/2th & Tower Grove St. around 5:20 a.m. on May 31st 1945

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

10. Usual occupation Nightwatchman

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 170

11. Industry or business A.S. Aloe

12. Name Unknown

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

14. Maiden name Unknown

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

Of autopsy 170

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Rose Katherine Wander

(b) Address 1633a Tower Grove Ave.

17. (a) Burial (b) Date thereof June 5, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

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

(b) Date of occurrence May 31st 1945

(c) Where did injury occur? 170 Tower Grove Ave
(City or town) (County) (State)

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

18. (a) Signature of funeral director Calvin E. Feutz Funeral Home

(b) Address 4828 Natural Bridge Blvd.

19. (a) JUN 4 1945 J. F. Brueck
(Date received from registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

Means of injury as above

23. Signature _____ (M. D. or other) _____
Date signed 6/4/45

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

John A. Mlinar

Licensed Embalmer No.

4186

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, fact should be so stated above.