

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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: Deaconess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 36 hours  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME ARTHUR J. BANGE  
3. (b) If veteran, name war None  
3. (c) Social Security No. \_\_\_\_\_

4. Sex M. Color or race W.  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mabel Bange  
6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased May 17 - 1873  
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 20  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Jann Bange  
13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Louise Mary  
15. Birthplace Greenfield Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mabel Bange

(b) Address 19 N. Hull Ave - Clayton, Mo.

17. (a) Burial (b) Date thereof 9-8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salhalla Cemetery

18. (a) Signature of funeral director Louis H. Bopp, Inc.

(b) Address Kirkwood, Mo.

19. (a) SEP 8 1945 (b) J. H. Deed  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 19 N. Hull Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month September day 6<sup>th</sup>  
year 1945 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from September 4, 1945 to September 6, 1945  
that I last saw him alive on September 5, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Myocardial Failure</u>	<u>2 days</u>
Due to <u>Chronic Myocarditis</u>	<u>5 years</u>
<u>chronic Bronchial asthma</u>	<u>5 years</u>
Due to <u>Arterid Sclerosis</u>	<u>5 years</u>

Other conditions (Include pregnancy within 3 months of death) 93d

Major findings:  
Of operations no operation  
Of autopsy no 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 \_\_\_\_\_  
(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?  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Wm. H. Norton (M. D. or other) M.D.  
Address 634 N. Grand Blvd. Date signed 9-7-45

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

20  
17  
9

8982

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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..... *Felix Blizard* .....

Licensed Embalmer No. *3034* .....

P. O. Address..... *Kirkwood 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.**