

S. No. 2
A-12-45
v. 5-17-39
I X47070

FILED APR 18 1947

Primary Registration District No. 1003

Registrar's No.

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:
3457^A INDIANA AV.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME KATHERINE Rogatschnig

3. (b) If veteran, name war..... NO

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

4. Sex FEMALE

5. Color or race..... W.

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

6. (b) Name of husband or wife..... MATTHEW Rogatschnig

6. (c) Age of husband or wife if alive..... 21 years

7. Birth date of deceased..... MARCH 12 1886
(Month) (Day) (Year)

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

61 — 9 hr. min.

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

10. Usual occupation..... HOUSEKEEPER

11. Industry or business..... OWN

12. Name..... HENRY WARGEN

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

14. Maiden name..... UNK. UNKNOWN

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

16. (a) Informant..... Matthew Rogatschnig

(b) Address..... 3457^A Indiana

17. (a) BURIAL (b) Date thereof..... APRIL 2-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... NEW SS. Peter & PAULS

18. (a) Signature of funeral director..... E. J. Schmeier

(b) Address..... 3125 Lafayette Av.

19. (a) APR 1 1947 (b) J. S. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... MISSOURI (b) County..... St. Louis

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

(d) Street No..... 3457^A INDIANA AV. (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... March day..... 30
year..... 1947 hour..... 7 minute..... 00 AM.

21. I hereby certify that I attended the deceased from..... Feb 15, 1947, to..... March 30, 1947.
that I last saw him alive on..... March 30, 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death..... Respiratory Hemorrhage

Due to.....

Due to..... Hepaticoma

Other conditions..... 59
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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?
(Specify type of place) (Means of injury)

While at work?.....

23. Signature..... John P. Schmeier (M. D. or other)

Address..... 506 Olive Date signed..... 4-1-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Jose B. Hollmer

Licensed Embalmer No. 41014

P. O. Address 3125 Lafayette Ave

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.