

REC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

4646  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791  
(b) Township ..... Primary Registration District No. 1003  
(c) City St. Louis (d) Street No. City Hospital No. 1 Registered No. 1339  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
D. Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 523

Elizabeth Winnesdoerfer

(a) Residence, No. 223 Robert St. 1  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF August WINNESDOERFER

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 19, 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
73 7 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
9. Industry or business in which work was done, as saw mill, bank, etc. nil  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

FATHER 13. NAME Theodore Koeln 0  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Koeln, Germany 6

MOTHER 15. MAIDEN NAME Agnes Stein 6  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Hosp. Info M. Kent  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Hope Cem. DATE Feb. 11 39

19. FUNERAL DIRECTOR (NAME) C. Hoffmeister U.A.L.Co.  
(ADDRESS) 7814 S. Broadway

20. FILED FEB 11 1939 J. B. Brubaker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/9/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 2/5/39 to 2/9/39, 19.

I last saw her live on 2/9/39, 19. Death is said

to have occurred on the date stated above, at 5.05 a.

The principal cause of death and related causes of importance were as follows:

Chronic anemia  
Acute bacterial heart disease  
Arteriosclerosis  
Bronchial  
Nephroses

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? 1  
If so, specify 1

(Signed) Jos. Z. Davis, M. D.  
(Address) City Hospital No. 1

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

*Linus E. Hoffmann*

Licensed Embalmer No. ....

3871

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, above space should be left blank.**