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.

CSD APR 12 1939

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

8477
Do not use this space.

791
1003
2242

1. PLACE OF DEATH

(a) County ..... / Registration District No. 791

(b) Township ..... / Primary Registration District No. 1003 Registered No. 2242

(c) City St. Louis / (d) Street No. City Hospital No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) 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.

D. 16376

2. PRINT FULL NAME 345 Delores Stollhans

(a) Residence, No. 902 Geyer St. 23
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joe Stollhans

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 29, 1916

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
22	8	9	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. hwk
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) Illinois

FATHER
13. NAME Fred Mertens
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana /

MOTHER
15. MAIDEN NAME Mary Behlevers /
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

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

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cem DATE March 9th, 1939

19. FUNERAL DIRECTOR (NAME) Edward Koch
(ADDRESS) 3516 4 14th Ste

20. FILED MAR 8 1939 J. D. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/7/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 2/8/39, 19, to 3/7/39, 19

I last saw her alive on 3/7/39, 19 Death is said to have occurred on the date stated above, at 4/35 p.m.

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

	Date of onset
Puerperium - Septicaemia	
(Cesarean Section) Lung abscess	
Pelvic abscess	
Bronchial pneumonia	
Type III	

Other contributory causes of importance:

14 5a

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? .....

If so, specify .....

(Signed) John N. Allen M.D., M. D.

(Address) City Hospital No. 1

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 1391

P. O. Address 4106 [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl
with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.