

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

8898
Do not use this space.

1939 APR 12 1939

791
1003

Registered No. 2663

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) or City..... St. Louis, Mo. (d) Street No..... City Infirmary..... 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 29 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 5800 Arsenal St. St. 13 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Michael Parmantje

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 23, 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 70 X 24

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. No Occupation.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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) Hungary. 6

FATHER 13. NAME Casper DeKold 6

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hungary. 6

MOTHER 15. MAIDEN NAME Barbara DeKold 6

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hungary.

17. INFORMANT (ADDRESS) E. Holony 5800 Arsenal St.

18. BURIAL, CREMATION, OR REMOVAL PLACE S. Teferet Park DATE 3-22-39.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) With Bros & Co. 2929 S. Jefferson

20. FILED MAR 21 1939 J. B. [Signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 3, 1939, to March 19, 1939

I last saw her alive on March 19, 1939 Death is said to have occurred on the date stated above, at 7:30 a. m. P. M.
 The principal cause of death and related causes of importance were as follows:

Hypertensive Cordis Vas. Disease

Date of onset

Other contributory causes of importance?

Name of operation..... Date of.....

What test confirmed diagnosis? N. T. P. Was there an autopsy? No

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? No

If so, specify (Signed) William Tapsen, M. D.

(Address) 5600 Arsenal St.

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 *Edgar F. Witt*

Licensed Embalmer No. *2117*

P. O. Address *2929 S Jefferson 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, above space should be left blank..