

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.

REC'D JUN 12 1939

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

16747
 Do not use this space.
 4281
 Registered No.

1. PLACE OF DEATH

(a) County 2 Registration District No. 791
 (b) Township 1 Primary Registration District No. 1008
 (c) City St. Louis (d) Street No. 4117a Flad Ave. 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.

2. PRINT FULL NAME

(a) Residence, No. 160 Elizabeth Favier St. 17
4117a Flad Ave. (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Late Albert Favier</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug. 19, 1876</u>				
7. AGE	YEARS <u>62</u>	MONTHS <u>8</u>	DAYS <u>17</u>	If LESS than 1 day, hrs. or min.
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. <u>Housewife</u>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Osage City Mo.</u>			
	13. NAME <u>Antone Pape</u>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>			
	15. MAIDEN NAME <u>Mary Huesti</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>				
17. INFORMANT <u>Mrs. Eilert Noel</u> (ADDRESS) <u>4117a Flad Ave.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary Cem.</u> DATE <u>5-9</u> 19 <u>39</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Kriegshauser Mortuary</u> <u>4228 So. Kingshighway</u>				
20. FILED <u>MAY 8 1939</u> <u>J.P. Budick</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-6 1939

22. I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to May 6, 1939
 I last saw her alive on May 6, 1939. Death is said to have occurred on the date stated above, at 2:05 P.M.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 5/3/39

Other contributory causes of importance: Hypertension not known

Name of operation none Date of _____
 What test confirmed diagnosis? _____ 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) Laroma J. Jankovic, M. D.
 (Address) 3515 S. Grand 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 *Reinhold K. Lohman*

Licensed Embalmer No. *3395*

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.