30

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 11 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23648

Registration District No. 791 Primary Registration District No. Registrar's No. 5921

1003

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: Lutheran Hospital 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 Days (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri 1 (b) ~~County~~

(c) City or town St. Louis (2)
(If outside city or town limits, write "RURAL")

(d) Street No. 4719 Primm
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mrs. Louise Stolle 3410

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William Stolle

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased March (Month) 22 (Day) 1864 (Year)

8. AGE: Years 75 Months 3 Days 13 If less than one day hr. min.

9. Birthplace Louisville, Kentucky 1
(City, town, or county) (State or foreign country)

10. Usual occupation Household

11. Industry or business

FATHER
12. Name John Obendoerfer 6
13. Birthplace Germany
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Eickmeyer 1
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm Stolle

(b) Address 4719 Primm St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7, 1939 (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Seidenwieder Funeral Coun Inc.

(b) Address 1936 St. Louis Ave

19. (a) 7/5/39 (Date received local registrar) (b) J. F. Bridick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5th year 1939 hour 1 minute 30 A M.

21. I hereby certify that I attended the deceased from Nov 5, 1938, to July 5, 1939 that I last saw her alive on July 4, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: General carcinomatosis originating in breast	?
Due to: Cont. Fracture Hip - June 9, 1939	
Due to:	
Other conditions (Include pregnancy within 3 months of death) Fracture Hip June 9, 1939 in Fall at home	

Major findings:
Of operations O.K. Dr. [illegible]
Of autopsy Jos. Dr. [illegible] 7/5/39

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide (specify) Fract. Hip

(b) Date of occurrence June 9, 1939

(c) Where did injury occur? at home St Louis Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place)

While at work? (e) Means of injury 4

23. Signature H A Schimmeman (M. D. or other)

Address 6811 Gravois Date signed 7/5/39

(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 Felix J. Krispin

Licensed Embalmer No. 3497

P. O. Address 1936 St. Fran

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

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