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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

31122

State File No.

REC'D OCT 14 1939

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 8185

1. PLACE OF DEATH:

(a) County 1

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital #1
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")

(d) Street No. 3508 Vista Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME Kathleen Stifel Anders 536

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Ray Anders

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

7. Birth date of deceased February (Month) 4, (Day) 1897 (Year)

8. AGE: Years 42 Months 7 Days 18 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Houseowrk

11. Industry or business At Home

FATHER
12. Name Philip F. Stifel 1
13. Birthplace Cincinnati (City, town, or county) Ohio 0 (State or foreign country)

MOTHER
14. Maiden name Lena Krell
15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Mrs W Eckardt
(b) Address 3523 University Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Wm J Robert
(b) Address 1905 So. Grand Blvd.

19. (a) SEP 23 1939 (Date received local registrar) (b) J F Bichick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 22nd day September year 1939 hour 11 minute 30 A M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cyanide Poisoning

Due to self administered

Due to in Room 921 Claridge

Other conditions Hotel on Sept 22 - 1939
(Include pregnancy within 3 months of death) Time Unknown

Major findings Of operation

Of autopsy Suicide

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

163

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

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence 9/22/39

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

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

While at work? (e) Means of injury

23. Signature Joseph M. Lillian (M.D. or other)

Address Deputy Coroner Date signed

(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.....

P. O. Address.....

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.