

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH: 1008

(a) County St. Louis **NOV 13 1939**

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

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

(d) Length of stay: In hospital or institution 10 days  
(Specify whether \_\_\_\_\_)

In this community Unknown  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 6

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

(d) Street No. 5566 Palm St.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Johanna Waidmann 355

8. (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 Married

6. (b) Name of husband or wife Fred Waidmann 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased October 8, 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

75 0 12 hr. min.

9. Birthplace Holstein, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business E

MOTHER FATHER

12. Name Emil Simon 7

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fred Waidmann  
(b) Address 5566 Palm St.

17. (a) Burial (b) Date thereof 10-23-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eriedens Calvary

18. (a) Signature of funeral director Math Hermann & Son  
(b) Address 2161 East Fair Ave

19. (a) OCT 21 1939 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20  
year 1939 hour 2:20 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10-5-39  
1939, to 10-20, 1939

that I last saw 21 alive on 10-19, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death By post static pneumonia  
Bronch.  
Dr. Emily

Due to Cardiac dilatation  
mitral regurgitation

Other conditions congenital thrombosis  
(include pregnancy within 6 months of death)  
enlargement of heart

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 92a

Duration 3 days

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) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (Means of injury)

23. Signature [Signature] (M. D. or other) MD  
Address 4356 Marine Date signed 10/20/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 1 x10311

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.

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**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 William G. Buchholz  
Licensed Embalmer No. 2110  
P. O. Address St. Louis Mo

**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.**