

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 492

Primary Registration District No. 5580

Registrar's No. 12-48

NOV 9 1939

1. PLACE OF DEATH:

(a) County JEFFERSON
(b) City or town RURAL - MERAMEC
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. JOSEPH'S HILL INFIRMARY 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 DAYS
(Specify whether
In this community 25 yrs (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 4220 A S. 38TH ST.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 11
year 1939 hour 2 minute 50 A.M.
21. I hereby certify that I attended the deceased from 9/19
1939, to 10/10, 1939;
that I last saw him alive on 10/10, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death
Broncho-pneumonia
Due to _____
Due to _____

Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

3. (a) PRINT FULL NAME ANTON OTZ 3210
3. (b) If veteran, name war NIL
3. (c) Social Security No. No.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife KATHERINE SCHAEFFER
6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased 3 3 1975
(Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 8
If less than one day _____ hr. _____ min.

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

10. Usual occupation LABORER, RETIRED

11. Industry or business STONE MASON

12. Name _____

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

14. Maiden name _____
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Brother Bonaventura

(b) Address St Joseph's Hill Inf. - Eureka, Mo.

17. (a) BURIAL (b) Date thereof 10/13/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial PARK

18. (a) Signature of funeral director Osian J. Holmeister

(b) Address 4016 Chippewa St. St. Louis, Mo.

19. (a) 11 Oct 1939 (b) James A. Thompson
(Date received by registrar) (Registrar's signature)

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)
(b) Means of injury _____

23. Signature Joseph S. Sargent (M. D. or other)

Address Eureka Mo. Date signed _____

WHILE FILLING IN USE UNFADING BLACK INK—MAKE 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.

1 X 3511

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
HEALTH CARE REGULATORY DIVISION
1984

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 Ernest W. Spillers

Licensed Embalmer No. 41080

P. O. Address 3528 Russell Pl.
St. Louis

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36450
Do not use this space.

1. PLACE OF DEATH

(a) County Jefferson Registration District No. 425-
(b) Township Fort Leane Primary Registration District No. 5580 Registered No.
(c) City (d) Street No. 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

Anton etz
(a) Residence, No. St. (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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 6 8

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.
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)
13. NAME Don't know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
15. MAIDEN NAME Don't know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE, 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 14 Dec 31 1939 J. J. Lawrence Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-11, 1939

22. I HEREBY CERTIFY, That I attended deceased from to, 19.....
I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at..... m.
The principal cause of death and related causes of importance were as follows:
Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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?, M. D.
I, so, specify J. S. Sargent (Signed) Eureka mo.
(Address)

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

