

FILED APR 15 1940

Registration District No.

Primary Registration District No.

Registrar's No.

2136

## 1. PLACE OF DEATH:

- (a) County St. Louis Mo  
 (b) City or town \_\_\_\_\_  
 (c) Name of hospital or institution: 5439 No. Euclid Ave  
 (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 days3. (a) PRINT  
FULL NAMEHelen Sickenberger3. (b) If veteran,  
name war.3. (c) Social Security  
No.

4. Sex

Female5. Color or  
raceW6. (a) Single, widowed, married,  
divorced MARRIED

6. (b) Name of husband or wife

HENRY6. (c) Age of husband or wife if  
alive 36 years

7. Birth date of deceased

3-28-1904  
(Month) (Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

351114

hr.

min.

9. Birthplace

St Louis Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Louis Mehrtzoff

13. Birthplace

St Louis Mo  
(City, town, or county) (State or foreign country)

14. Maiden name

Helen Couay  
(City, town, or county) (State or foreign country)

15. Birthplace

St Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Louis Mehrtzoff

(b) Address

5439 No. Euclid17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

3/5/40  
(Month) (Day) (Year)

(c) Place: burial or cremation

Calvary Cem

18. (a) Signature of funeral director

SULLIVAN

(b) Address

7849 No. Euclid Ave19. (a) APR 4 1940

(b)

[Signature]  
(Date received local registrar) (Registrar's name)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County \_\_\_\_\_  
 (c) City or town St. Louis 7  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5439 No. Euclid  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2  
year 1940 hour 5 minute 30 p. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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)

By means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other)Address [Address] Date signed 3.4.40

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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.....

*Albert Mayfield*

Licensed Embalmer No.....

*3077*

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.**