

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

20291

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. _____

5239

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: 4723 Tesson Str.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Mary C. Clausen 425

8. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Peter Clausen 6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased Jan. 25 1860
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 4 20 hr. min.

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

10. Usual occupation House Work

11. Industry or business at Home

12. Name Lorenz Helgoth

18. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Christine Burger

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

16. (a) Informant's own signature Geo. Machenheimer

- (b) Address 4723 Tesson

17. (a) Burial (b) Date thereof June 17 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation St. Mathews

18. (a) Signature of funeral director H. Schumacher

- (b) JUN-17 1940 3013 Meramec

19. (a) _____ (b) J. F. Bredeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
 (c) City or town St. Louis 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4723 Tesson Str.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
 year 1940 hour 5 minute 40 P.M.

21. I hereby certify that I attended the deceased from JUNE 9th
 1940, to JUNE 14th 1940;
 that I last saw her alive on JUNE 14th 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE Duration 6 DAYS

Due to ARTERIO-SCLEROSIS 10 YRS

Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations 6

Of autopsy _____

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)
 (e) Means of injury _____

28. Signature E. M. Schurich, M. D. (M. D. or other)

Address 2327 S. 24 St Date signed June 15th

12 x Kamin
2577 8/14

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.....

Clarence Kachow

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Clarence Kachow

Licensed Embalmer No. *3093*

P. O. Address *3013 Merame*

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.