S. No. 2
—11-10-39
. 5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20502

1940 JUL 17

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 5459

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:
Lutheran Hospital
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County (City)

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

(d) Street No. 2117 Chippewa St 24
(If rural, give location)

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

3. (a) PRINT FULL NAME Mildred Josephine Wack. 2nd

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female.

5. Color or race White.

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

6. (b) Name of husband or wife George. Wack.

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased September (Month) 24th (Day) 1904. (Year)

8. AGE: Years 35 Months 8 Days 28 If less than one day hr. min.

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

10. Usual occupation At Home.

11. Industry or business

FATHER
12. Name Henry Fohr.
13. Birthplace St. Louis. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Kate Brohammer.
15. Birthplace St. Louis. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant George Wack.
(b) Address 2117 Chippewa St.

17. (a) burial, (Burial, cremation, or removal) (b) Date thereof June 25 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery.

18. (a) Signature of funeral director Ziegenheim Bros
(b) Address 2621-23 Cherokee St.

19. (a) JUN 25 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22 year 1940 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from June 3, 1940, to June 22, 1940, that I last saw her alive on June 22, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Vascular Heart Disease (Mitral Insufficiency) — Duration years

Due to: Rheumatism — years

Due to: Uterine Myomata, Ovarian Cyst Non Malignant

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations: Uterine Myomata with Ovarian Cyst
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. Lewis Hutton (M. D. or other)
Address 3606 Iowa Date signed 6/24/40

(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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.