

S. No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23670

State File No.

6115

ED AUG 25 1940 791
Registration District No.

Primary Registration District No. 1003

Registrar's No.

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:
DEACONESS HOSP. 1
(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 days

8. (a) PRINT FULL NAME VENILA GELDBACH.
8. (b) If veteran, name war no
8. (c) Social Security No. NO

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife HERBERT.
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased JULY 11 - 1906
(Month) (Day) (Year)

8. AGE: Years 34. Months - Days 9~~th~~ If less than one day _____ hr. _____ min.

9. Birthplace K. ST. LOUIS. ILL
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business AT HOME

MOTHER FATHER { 12. Name Geo. BUCHNER.
18. Birthplace ST LOUIS MO (D)
(City, town, or county) (State or foreign country)
14. Maiden name LOUISA NULL
15. Birthplace K. ST. LOUIS ILL
(City, town, or county) (State or foreign country)

16. (a) Informant HERBERT GELDBACH.
(b) Address 4150 HOLLY HILLS.

17. (a) BURIAL (b) Date thereof JULY 23-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation E. ST. LOUIS. ILL

18. (a) Signature of funeral director J. P. French - J.
(b) Address 7128 Michigan
19. (a) JUL 2 1940 (b) J. F. Fredrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County _____
(c) City or town ST. LOUIS 1
(If outside city or town limits, write "RURAL")
(d) Street No. 4150 HOLLY HILLS.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 hour 11 minute 15 p. M.
21. I hereby certify that I attended the deceased from 4-5
1940, to 7-20, 1940
that I last saw her alive on 7-20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage into uterus Duration 2 1/2 hrs
Due to Premature separation of placenta 2 1/2 hrs
Due to Epilepsy - 7 yrs
Other conditions Chl. nephritis 8 mo
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations none
Of autopsy none
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) no
(b) Date of occurrence no
(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? no (Specify type of place) (e) Means of injury no
23. Signature W. H. Klumpp (M. D. or other) MD
Address 340 Bernuda Date signed 7-22-40

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

144/2

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 Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 732 Lemay

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23670
Registrar's No. 6115

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 days)

3. (a) PRINT FULL NAME

Jenila Gelobach

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

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

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

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) 11-25-40 (b) J.F. Bredek (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 40 hour minute M.

21. I hereby certify that I attended the deceased from 19..... to 19..... that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage into uterus - placenta
Due to premature separation placenta
Due to lithem delivered 7-20-40

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 14 hrs

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

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

SUPPLEMENTARY

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

