

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003State File No. **33666**  
Registrar's No. **8363**NOV 16 1940 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town Saint Louis Missouri.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 6046 Pernod 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 days

3. (a) PRINT FULL NAME Barbara A. Feder,3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife John Feder 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased October 24th, 1849.  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
90 11 12 hr. min.9. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Casper Mathis13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)14. Maiden name Unknown  
15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Laura Burns(b) Address 6046 Pernod Ave.17. (a) Burial (b) Date thereof. Oct. 9th, 40.  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Park Lawn Cemetery.18. (a) Signature of funeral director Ziegenhein Bros.(b) Address 2323 Cherokee Street.19. (a) Oct 8 1940 (b) J. H. [Signature]  
(Time received by registrar) (Registrar's Signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County \_\_\_\_\_  
 (c) City or town Saint Louis, 14  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 6046 Pernod Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6th.  
year 1940. hour 10 minute 45 P. M.21. I hereby certify that I attended the deceased from 10-1-37  
10-6, 1940,  
that I last saw her alive on 10-4, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Chronic  
renal insufficiency  
due to  
arteriosclerosis  
Duration 10 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic Hypertension  
(Include pregnancy within 3 months of death)Major findings: None  
Of operations \_\_\_\_\_

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 \_\_\_\_\_23. Signature [Signature] (M. D. or other) \_\_\_\_\_Address 2844 [Address] Date signed 10-7-40

**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 W. E. Morris

Licensed Embalmer No. 3360

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.**