

No. 2  
1-10-39  
-17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

36331

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2033

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Carondelet Township, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 396 Days  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 2806-a - N. Sarah  
(If rural, give location)

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

3. (a) PRINT FULL NAME AUDREY STIMEL

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29<sup>th</sup>  
year 1940 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from  
9-23 1939, to 10-29 1940  
that I last saw him alive on 10-29 1940  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Earl 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 5-11-1906  
(Month) (Day) (Year)

Immediate cause of death  
Pulmonary Tuberculosis

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

Due to 23

Other conditions Amyloidosis  
(Include pregnancy within 3 months of death)

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

34 5 18 hr. min.

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

10. Usual occupation Beauty Operator

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

12. Name Fred Kroecker

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

14. Maiden name E. Thum Bolton

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

16. (a) Informant Audrey Stimel

(b) Address 2806-a N. Sarah

17. (a) Burial (b) Date thereof 10/31/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Sullivan

(b) Address 2849 N. Euclid

19. (a) OCT 29 1940 (b) R. Meyer M.D.  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy conforms above.

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 John H. Graham Jr. (M. D. or other) \_\_\_\_\_  
Address Robert Koch Hospital Date signed 10-22-40

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

**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 Alben Mayfield

Licensed Embalmer No. 3677

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.**