

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4177

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 116

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Beverly Hills  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7015 Hunter Av  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 mo  
(Specify whether)

In this community  
years, months or days

8. (a) PRINT FULL NAME Dorthea Caroline Pratte

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased May 7 1859  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 8 10 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housekeeper

11. Industry or business

MOTHER FATHER { 12. Name Fredrick Pratte  
13. Birthplace Germany  
14. Maiden name Unknown  
15. Birthplace Germany

16. (a) Informant Selma Bienbeck

(b) Address 7015 Hunter Av

17. (a) Burial (b) Date thereof 1-19-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dr. John S. ...

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

(b) Address Ballwin, Mo.

19. (a) JAN 18 1941 (b) J. R. Meyers  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96  
(c) City or town Ballwin  
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17  
year 1941 hour 5 minute 0 a.m.

21. I hereby certify that I attended the deceased from Oct 10 1940 to Jan 17 1941;  
that I last saw her alive on Jan 17 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Duration \_\_\_\_\_

Due to Arteriosclerosis

Due to Age

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations 9/4/40  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underlines 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)  
(c) Means of injury \_\_\_\_\_

23. Signature J. R. Meyers (M. D. or other) MD  
Address 340 Pennell Ave Date signed 1-17-41

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

96  
0  
0

D & G MANTYER  
340 Bermuda Ave

EMBALMER

**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 Howard R. Powell

Licensed Embalmer No. 3114

P. O. Address St. Louis Mo

**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.**

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(a) County St. Louis

(b) City or town Beverly Hills  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7015 Hunter Ave  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Northea Caroline Peattie

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 11  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE:			If less than one day	
Years	Months	Days	hr.	min.
<u>81</u>	<u>8</u>	<u>10</u>		

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

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 Geo. D. Klenke (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

