

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

0. 2  
-4-41  
17-39  
X2839

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **19915**  
**4727**  
Registrar's No.

Registration District No. **103**  
**791**

Primary Registration District No. **103**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **3223 Dakota /**  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **000**  
(c) City or town **St. Louis** **1713**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3223 Dakota** **7**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Carolina Rudolf**  
3. (b) If veteran, name war **No.** 3. (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 **John A. Rudolf** 6. (c) Age of husband or wife if alive **69** years  
7. Birth date of deceased **January 5 1879**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **June** day **5<sup>th</sup>**  
year **1941** hour **seven** minutes **five** A.M.  
21. I hereby certify that I attended the deceased from **July 6<sup>th</sup>**  
19**40** to **June 4<sup>th</sup>** 19**41**;  
that I last saw **her** alive on **June 4** 19**41**;  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Chronic Myocarditis** Duration \_\_\_\_\_

8. AGE: Years **62** Months **5** Days **--** If less than one day  
hr. min.

Due to **arterial sclerosis**

9. Birthplace **New Hanover / Illinois**  
(City, town, or county) (State or foreign country)

Due to **Interstitial Nephritis, acute caused by arterial sclerosis**

10. Usual occupation **Housewife**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

PHYSICIAN \_\_\_\_\_

12. Name **Henry Washausen**

Major findings: Of operations **93d**

13. Birthplace **Germany**

Of autopsy **93c**

14. Maiden name **Margarete Schwartztrauber**

Underline the cause to which death should be charged statistically.

15. Birthplace **Germany**

22. If death was due to external causes, fill in the following:

16. (a) Informant **John A. Rudolf**

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Address **3223 Dakota**

(b) Date of occurrence \_\_\_\_\_

17. (a) **Burial** (b) Date thereof **6/7/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? (City or town) (County) (State)

(c) Place: burial or cremation **St. Paul-Columbia, Ill**

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director **Edmund A. ...**

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

(b) Address **3013 Meramec**

23. Signature **Dr. Gerald Bender** (M. D. or other) **PC**

19. (a) **JUN 6 1941** (b) **J. F. Brudich**  
(Date received local registrar) (Registrar's signature)

Address **3215 Lafayette** Date signed **June 5 41**

(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 \_\_\_\_\_  
George Dechaubault Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 2906

P. O. Address. 3013 Duane

**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, fact should be so stated above.**