

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 39980
Registrar's No. 9690

JAN 24 1942 791
Registration District No.

Primary Registration District No.

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

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:
Little Flower Retreat House
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 yrs (Specify whether
In this community 60 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 23
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2500 S. 18th. St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 22

3. (a) PRINT FULL NAME Dora Hanreitta Rothkopf

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased Mar 12th. 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
88 8 23 hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

12. Name John Hensing

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

14. Maiden name Unknown

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

16. (a) Informant John Rothkopf

(b) Address 1215 Amherst St

17. (a) Burial (b) Date thereof 12/9/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Harrigan & Sheahan Und Co

(b) Address 4415 Washington Blvd.

19. (a) DEC 9 1941 (b) J. F. Wasedek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 5th
year 1941 hour 6:00AM minute _____ M.

21. I hereby certify that I attended the deceased from 11/26/41
to 12/5/41
that I last saw her alive on 12/5/41
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Congestion Duration 5 days

Due to Chronic Passive Congestion 10 days

Due to Chronic Myocardial Disease 3-4 years

Other conditions (Include pregnancy within 3 months of death)

Major findings:
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 Paul B. Webb (M. D. or other) M.D.
Address 1920 Sedway Date signed 11/6/41

*Dr. Paul M. Webb
1924*

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..... *Homer W. Fritz*

Licensed Embalmer No. *3882*.....

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, fact should be so stated above.