

FILED DEC 1 1942

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9788

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:
3840 LACLEDE AVE. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **23 YEARS** (Specify whether years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **MO.** (b) County..... **000**

(c) City or town..... **ST. LOUIS** **189**
(If outside city or town limits, write "RURAL")

(d) Street No..... **3840 LACLEDE AVE.**
(If rural, give location)

(e) Citizen of foreign country?..... **NO** (Yes or No)

If yes, name country..... **0**

3. (a) PRINT FULL NAME **MARY A. STUCKENSCHNEIDER**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **NOV.** day..... **21**
year..... **1942** hour..... **10** minute..... **55** A.M.

4. Sex..... **FEMALE** 5. Color or race..... **WHITE** 6. (a) Single, widowed, married, divorced..... **MARRIED**

6. (b) Name of husband or wife..... **CHRIST STUCKENSCHNEIDER** 6. (c) Age of husband or wife if alive..... **86** years

7. Birth date of deceased..... **FEBRUARY 3, 1863**
(Month) (Day) (Year)

I hereby certify that I attended the deceased from **Nov 21 1942** to **Nov 21 1942** that I last saw him alive on **Nov 20 1942** and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
79	9	18	hr. min.

Immediate cause of death..... **cerebral hemorrhage** **5 days**

Due to..... **arterio. sclerosis** **2 years**

9. Birthplace..... **WESTPHALIA MO. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **AT HOME**

Other conditions..... **none**

Major findings: Of operations..... **none**

Of autopsy..... **none**

11. Industry or business.....

12. Name..... **D. K. DEKNITE**

13. Birthplace..... **GERMANY 4**
(City, town, or county) (State or foreign country)

14. Maiden name..... **P. K. HANKER**

15. Birthplace..... **GERMANY 4**
(City, town, or county) (State or foreign country)

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

(a) Accident, suicide, or homicide (specify)..... **no**

(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?.....

16. (a) Informant..... **CHRIST STUCKENSCHNEIDER**

(b) Address..... **3840 LACLEDE AVE.**

While at work?..... (Specify type of place) (2) Means of injury

17. (a) **BURIAL** (b) Date thereof..... **NOV. 24, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **New S. S. Peter & Paul**

18. (a) Signature of funeral director..... **Arthur J. Donnelly**

(b) Address..... **3840 Lindell Blvd.**

19. (a) **NOV 23 1942** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

23. Signature..... **W. Schneider** (M. D. or other) **MD.**

Address..... **3318 S Grand** Date signed..... **11-23-42**

MOTHER, FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr
3318
1-3 PM
Dr. Sehnicker
Dr. Sehnicker

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 Stanley Marshall
Licensed Embalmer No. 2868
P.O. Address 3840 Lindell Blvd

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.