

U. S. No. 2
FORM 7-342
Rev. 5-17-39
1 X2873

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 21 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 412

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:
3641 Childress
(If not in hospital or institution, write street number or location)

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

In this community 70 yrs.
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. 3641 Childress
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Marie Kathryn Sanftleben

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12
year 1943 hour 8 minute 55 P.M.

21. I hereby certify that I attended the deceased from 12-31-
1935 to 1-12 1943
that I last saw her alive on 1-12 1943
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 Widowed

6. (b) Name of husband or wife A.G. Sanftleben 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 23 1852
(Month) (Day) (Year)

Immediate cause of death:
Myocarditis chronic
Vascular disease
Arterio sclerosis

Due to _____

Due to _____

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

8. AGE:	Years	Months	Days	If less than one day
	<u>90</u>	<u>8</u>	<u>19</u>	_____ hr. _____ min.

9. Birthplace Cuxhaven Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Doescher

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

14. Maiden name Dorothea Stehr

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: None

Of operations _____

Of autopsy None

16. (a) Informant Mrs. Martha E. Dyer

(b) Address 3641 Childress

17. (a) Burial (b) Date thereof 1-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters

18. (a) Signature of funeral director John J. Ziegenhein & Sons

(b) Address 7027 Gravois Ave

19. (a) JAN 15 1943 (b) J. F. Bredack
(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 Philip Schuck (M.D. or other) _____

Address 1703 Grand Date signed 1-20-43

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..... *B. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *7027 Graves*

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.