

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

BUREAU OF THE CENSUS
FILED JUN 12 1943

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 1330

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

1. PLACE OF DEATH: ST LOUIS

(a) County ST LOUIS

(b) City or town RICHMOND HTS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST MARYS HOSP O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 WEEK (Specify whether)

In this community 1 WEEK
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State CAL (b) County SAN FRANCISCO

(c) City or town SAN FRANCISCO 0
(If outside city or town limits, write "RURAL")

(d) Street No. 256 De Long St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME IRENE KATHRYN PEISTERER

3. (b) If veteran, name war _____ 3. (c) Social Security No. 567-28-7626

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

6. (b) Name of husband or wife WACK W PEISTERER 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased AUG 29 1914
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>28</u>	<u>9</u>	<u>5</u>	<u>14 hr. 45 min.</u>

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER

12. Name JOHN D SPARKS

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

14. Maiden name MAY SORELLE

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

16. (a) Informant Jack W. Plinton

(b) Address 256 DeLong St. S.F. Cal.

17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 6-9-43
(Month) (Day) (Year)

(c) Place: burial or cremation SAN FRANCISCO, CAL.

18. (a) Signature of funeral director Walter Bookman

(b) Address 6536 Clayton Rd

19. (a) 6-5-43 (Date received local registrar) (b) C. M. Moran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4th year 1943 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from May 28, 1943 to June 4, 1943.
that I last saw her alive on June 4, 1943.
and that death occurred on the date and hour stated above.

Immediate cause of death Acute febrile meningitis Duration 5 1/2 days

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN 14
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 Walter Bookman (M.D. or other) MD

Address 5400 Arsenal St Date signed 6/4/43

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No.

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.