

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

**FILED** AUG 18 1949 1818

1003

Registrar's No. 7179

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4265 Cleveland /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 60 Years (Specify whether 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. 4265 Cleveland  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma Soukup

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Vencel 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 5 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 5 3 hr. min.

9. Birthplace St. Charles Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation House-Work

11. Industry or business

MOTHER FATHER { 12. Name Wm. Hagemann  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Emma Degge  
15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas W. Soukup

(b) Address 5467 Ashland

17. (a) Burial (b) Date thereof 8-11-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belleville Illinois Green Mt.

18. (a) Signature of funeral director J. Schumacher

(b) Address 3013 Meramec

19. (a) AUG 9 1949 (b) J. Brebeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8  
year 1943 hour 7 minute 30 a.m.

21. I hereby certify that I attended the deceased from July 25 1945 to Aug 8 1945  
that I last saw her alive on aug 7 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions AM  
(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) Means of injury \_\_\_\_\_

23. Signature Carl J. [illegible] (M. D. or other) \_\_\_\_\_

Address 3604 [illegible] Date signed 8-9-45

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

10.11.1960

Identified by

11-17 60.M

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 W.E. Morris

Licensed Embalmer No. 3360

P. O. Address 605 Ramcke Pl

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.