

S. No. 2
DM-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40430**
Registrar's No. **11761**

FILED JAN 4 1948
Registration District No. **1248**

Primary Registration District No. **1003**

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

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:
Park Lane Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Unknown (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mary Schimpfle
(b) If veteran, name war --
(c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Peter Schimpfle
6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased August 3, 1910
(Month) (Day) (Year)

8. AGE: Years 33 Months 4 Days 24
If less than one day _____ hr. _____ min.

9. Birthplace Czecklo-Slovakia
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER

12. Name William Fiala
13. Birthplace Czecko-slovakia
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Peter Schimpfle

(b) Address 3704 Fannie, Lemay, Mo.

17. (a) Burial (b) Date thereof 12 30 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Stuber-Hildesh-Wad. Co.

(b) Address 3634 Gravois Avenue

19. (a) DEC 29 1943 (b) J. Z. Brudeck
(Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Lemay, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 3704 Fannie
(If rural, give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 27
year 1943 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from 12-12-43, 19____, to 12-27-43, 19____;
that I last saw her alive on 12-27-43, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Venous

Due to _____

Due to _____

Other conditions 12/27/43
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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)
(c) Means of injury _____

23. Signature J. Z. Brudeck (Other) m. o.
Address 4930 Date signed 12-27-43

6

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..... *Frank G. Ireland*

Licensed Embalmer No. *2645*

P. O. Address..... *St. Lawrence*

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.