

#22070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1911
State File No. _____
Registrar's No. 4017

FILED MAY 12 1945 818

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution lmo 19 days
(Specify whether years, months or days) 2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL") 824
(d) Street No. 3314 Texas Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country No.

3. (a) PRINT FULL NAME NELLIE WHIPRECHT

3. (b) If veteran, name war no 3. (c) Social Security No. 276-18-8222

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 3 divorced

6. (b) Name of husband or wife divorced (c) Age of husband or wife if alive divorced years

7. Birth date of deceased April 5 1895
(Month) (Day) (Year)

8. AGE: Years 50 Months 0 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business Alberton Hotel Cleveland

12. Name Wm. S. Ogle

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

14. Maiden name Phyllomene Galvan

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

16. (a) Informant Mildred Ogle

(b) Address 3314 Texas Ave.

17. (a) Burial (b) Date thereof 5/7/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Suedmeyer & Sons

(b) Address 3934 N. 20 St.

19. (a) MAY 7 1945 (b) J. F. Brede
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th
year 1945 hour 6:55 minute P. M. _____

21. I hereby certify that I attended the deceased from 3/15/45
19____ to 5/4/45 19____

that I last saw h. OT alive on 5/4/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus viridans bacteremia Duration _____

Due to 97

Due to Psychosis with cerebral arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Ellie J. Light (M. D. or other) _____
Address 1515 Lafayette 5/5/45 signed _____

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

MOTHER FATHER

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.....

Alfred J. Boedeker

Licensed Embalmer No. *2663*

P. O. Address. *3934 Alpha*

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.