

FILED OCT 25 1945 318

STANDARD CERTIFICATE OF DEATH

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

9007

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jewish Hospital 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 weeks  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Gertrude S. Stadler

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

4. Sex F. / 5. Color or race W.  
6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Fred Stadler 6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased. July 8 1865  
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Julius Schweich

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

14. Maiden name Jeanette Loeb

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

16. (a) Informant Mrs. Louis Sitem  
(b) Address 6843 Waterman Ave

17. (a) Burial (b) Date thereof 10/19/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer  
(b) Address 4356 Lindell

19. (a) OCT 18 1945 J. F. Bredek  
(Date received local registrar) (Registrar's signature)

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. 5568 Waterman Ave  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17  
year 1945 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 8, 1945, to Oct 17, 1945;  
that I last saw her alive on Oct 17, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of ovary

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

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

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

23. Signature Hermon M. Meyer (M. D. or other) M.D.  
Address 508 N. Grand Date signed 10/17/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
17  
9

**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 Elmer R. Sadwell

Licensed Embalmer No. 4077

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.**