DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35888

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9585

1. PLACE OF DEATH:

(a) County
(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 ~~Avenue~~ Lane Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4125 N Natural Bridge
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

000
1017

3. (a) PRINT FULL NAME George Stemp

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced D

6. (b) Name of husband or wife

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

7. Birth date of deceased — (Month) — (Day) — (Year)

8. AGE: Years 80 Months — Days — If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name [illegible]
13. Birthplace [illegible] (City, town, or county) D (State or foreign country)

MOTHER
14. Maiden name [illegible]
15. Birthplace [illegible] (City, town, or county) D (State or foreign country)

16. (a) Informant Dena Rothman
(b) Address 4567 W Wheeler

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 6 - 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Fred Wilkinson
(b) Address 4535 Washington

19. (a) NOV 6 1945 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4th year 1945 hour 10:00 minute A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Retro-Peritoneal Hemorrhage; Fracture of Pelvis; Fracture Right Femur; when struck by

Due to an automobile driven by one James Benjamin Rutberry in front of 4111

Due to W. Natural Bridge Ave., around 12:20 A.M. Oct. 31, 1945.

Duration

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) Accident
(b) Date of occurrence Oct. 31, 1945
(c) Where did injury occur? St. Louis, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Public Place (Specify type of place)
While at work? (e) Means of injury

23. Signature Alfred J. Perry (M. D. or other)
Address Deputy Coroner Date signed 11-5-45

(Licensed Embalmer's Statement on Reverse Side)

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

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.....By W Wilkins

Licensed Embalmer No.....3577

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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9585

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME George Stemp

3. (b) If veteran, name war

3. (c) Social Security No. Single

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife —

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years aft 80 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) NOV 29 1945 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

35888