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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39832

FILED JAN 13 1946

Registration District No. 3186 Primary Registration District No. 1003 Registrar's No. 11209

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

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: PEOPLES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 HRS (Specify whether
In this community 6 HRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLIONIS (b) County

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

(d) Street No. 616 So. MARKET ST NR.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME INFANT - STELLHORN

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 SINGLE

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

7. Birth date of deceased DECEMBER (Month) 19 (Day) 1945 (Year)

8. AGE: Years ~~6 hrs~~ Months Days If less than one day 6 hr. min.

9. Birthplace ST LOUIS (City, town, or county) MO. (State or foreign country)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name WILLIAM H. STELLHORN
13. Birthplace RED BUD (City, town, or county) ILL (State or foreign country)

MOTHER
14. Maiden name YVONNE EVERDINE
15. Birthplace RED BUD (City, town, or county) ILL (State or foreign country)

16. (a) Informant WILLIAM H STELLHORN
(b) Address RED BUD, ILL.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 12-21-1945 (Month) (Day) (Year)
(c) Place: burial or cremation RED BUD ILL.

18. (a) Signature of funeral director KOCH FUNERAL HOME
(b) Address RED BUD ILL

19. (a) DEC 21 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER Day 19th
year 1945 hour 7 minute 00 M.

21. I hereby certify that I attended the deceased from 12:29 Pm Dec 19 1945 to 12: Dec 19 1945;
that I last saw him alive on Dec 19, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia Neon Atrophy — Duration 6 hr

Due to do

Due to

Other conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy No

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 W. H. Mansiff (M. D. or other)
Address 4330a Easton Date signed 12-21-45

(Licensed Embalmer's Statement on Reverse Side)

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.....Not Embalmed.....

Licensed Embalmer No.....

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.