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DEPARTMENT OF COMMERCE - THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. 10706,
Registrar's No. 656

Registration District No. 317 Primary Registration District No. 6876

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

1. PLACE OF DEATH:
(a) County Saint Louis Co.
(b) City or town Affton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5310 Heege Road.
(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 Missouri. (b) County St. Louis 9/5
(c) City or town Affton
(If outside city or town limits, write "RURAL")
(d) Street No. 5310 Heege Road.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret Angeli
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 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: July 17th, 1910.
(Month) (Day) (Year)
8. AGE: Years 35 Months 7 Days 27 If less than one day hr. _____ min. _____

9. Birthplace: Saint Louis, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Dress mfg.

11. Industry or business _____

12. Name Mathias Angeli

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

14. Maiden name Thresa Heckel

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

16. (a) Informant Mathias Angeli
(b) Address 5310 Heege Road.

17. (a) Burial (b) Date thereof March 18, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery.

18. (a) Signature of funeral director Zeggenhous Bros.
(b) Address 6209 Gravois Ave.

19. (a) 3-20-46 (b) Ed W. Gaman M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14th,
year 1946. hour 7 minute 0 P. M.

21. I hereby certify that I attended the deceased from March 14, 1946 to March 14, 1946
that I last saw her alive on March 14, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to Principally carcinoma of the lungs.
Due to 4rd

Other conditions metastases
(Include pregnancy within 5 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 [Signature] (M. D. or other) [Signature]
Address 3606 Gravois Date signed 3-15-46

Dr. M. W. Spivey
3606 Stephens
La 7380
1/6/33

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 *Homer W. Fritz*
Licensed Embalmer No. *3882*
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Saint Louis Co
(b) City or town Atton
(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

3. (a) PRINT FULL NAME Margaret Angeli
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 17
(Month) (Day) (Year)

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

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

10. Usual occupation Ind. Mfg

11. Industry or business Ind. Mfg. Dept. Co.

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

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

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

10706