

U. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18001**  
Registrar's No. **1072**

**FILED MAY 20 1946**  
Registration District No. **27**

Primary Registration District No. **6676**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
16860

**1. PLACE OF DEATH:**

(a) County St. Louis

(b) City or town Rural - Gravois  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
R. 1 Box 14400 Sappington Mo.  
(If not in hospital or institution, write street number or location)

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

In this community Life.  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Louis Aff

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 Married

6. (b) Name of husband or wife Louisa 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Dec. 26th, 1871  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>74</u>	<u>4</u>	<u>18</u>	hr. _____ min. _____

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

10. Usual occupation retired truck farmer

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

**MOTHER, FATHER**

12. Name John George Aff

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

14. Maiden name Marie Lesch

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

16. (a) Informant Mabel Kuhn

(b) Address 147 E. Rose Hill, Kirkwood Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/46  
(Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director J. L. Ziegenhein & Sons

(b) Address 7027 Gravois Ave.

19. (a) 5-17-46 (Date received local registrar) (b) E. J. Kabanian (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 96

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

(d) Street No. R 1 Box 1400 Sappington, Mo. 0  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 14th  
year 1946 hour 12 minute 40 A. M.

21. I hereby certify that I attended the deceased from June 1  
1930 to May 14 1946  
that I last saw him alive on May 14 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 6 yrs  
acute indigestion 5 hrs  
Due to Ulcer of the duodenum 3 yrs  
healed 93-d

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

Other conditions 93-d  
(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) Means of injury \_\_\_\_\_

23. Signature Walter Kelley (M. D. assistant)  
Address 9915 Gravois Apt. 23 Date signed May 15/46

OCT 8 1946

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**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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 7027 Gravois

**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.**