

1-17-39
X36671

FILED MAY 20 1946

Registration District No. 57 Primary Registration District No. 4467 Registrar's No. 1069

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Valley Park, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mohr Nursing Home 4
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 DAYS
 In this community 9 - DAYS
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis 17
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5208 Roberts 9
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MINNIE Pfaff
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 2
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
 alive _____ years
7. Birth date of deceased MARCH 24, 1868
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 12
 year 1946 hour 5 minute 03 P.M.
21. I hereby certify that I attended the deceased from May 3, 1946 to May 12, 1946
 that I last saw h. or alive on May 12, 1946
 and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 1 Days 10 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral hemorrhage
 Due to Arterio-sclerosis
 Due to Senility

9. Birthplace CARLINVILLE, Ill. (City, town, or county) (State or foreign country)
10. Usual occupation Nil

Other conditions Fracture of hip
 (include pregnancy within 3 months of death)
Chronic bronchitis
Major findings:
 Of operations _____
 Of autopsy 850
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Henry Riefenberg
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Haganpahl
15. Birthplace ? (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ida Yeager
(b) Address 5208 Roberts
17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof 5-14-46
 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mathews Cemetery**

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 _____

18. (a) Signature of funeral director Ortman Funeral Home
(b) Address 9222 Backland Rd. Overland, Mo.
19. (a) 5-17-46 (Date received local registrar) **(b) E. J. McDevran** (Registrar's signature)

23. Signature Chas. J. Siebert (M. D. or other) MD
Address Valley Park Mo **Date signed** 5/13/46

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 *W. C. Ottmann*.....

Licensed Embalmer No. *3478*.....

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.

Regarding the supplementary death certificate for Mrs. Minnie Pfaff, I have not signed this as I do not consider the accident a cause of death.

Mrs. Pfaff's death was expected at any time for several days before the accident occurred. Her breathing was very difficult as her lungs were filling with fluid and a steam kettle was placed beside the bed to ease her respirations. Because of her mental condition she had to be restrained with a band around her body, but in spite of this she managed to work herself loose sufficiently to get the upper part of her body over the side of the bed and upset the steam kettle, burning the side of her face and neck. I saw the patient less than half an hour after the accident happened and she was not suffering from shock, the pain was subsiding and her general condition did not seem to be changed in any way. This happened on the 8th of May and she did not die until the 12th of May.

Under the circumstances I do not see why this accident should be considered a cause of death.

Sincerely yours,

Edward J. Behr M.D.

18091

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 1069

Registration District No. 317

Primary Registration District No. 4467

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Valley Park
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Murrel C. Jeff
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar 24 (Month) (Day) (Year)

8. AGE: Years 80 Months 0 Days 0 (if less than one day) hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(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 _____ year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____ 19____; that I last saw him _____ 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 (over)

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) (c) Means of injury _____

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

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

16970

SUPPLEMENTARY

18891