

FILED MAY 17 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4137

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME MARGARET CUSTER

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. Widow

6. (b) Name of husband or wife. Edward E. 6. (c) Age of husband or wife if alive. -- years

7. Birth date of deceased. Oct. 14 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>6</u>	<u>21</u>	hr. _____ min.

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

10. Usual occupation. Home

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

MOTHER FATHER {

12. Name John Suttmoeller

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

14. Maiden name Unknown

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

16. (a) Informant: Fred Wiegert  
(b) Address 6732 Bonnie Ave.

17. (a) Burial (b) Date thereof 5/9/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Pauls Churchyard

18. (a) Signature of funeral director Wacker-Helbich  
(b) Address 3634 Gravois Ave.

19. (a) MAY 7 1946 J. F. Braddock  
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4308 Warne  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5  
year 1946 hour 12:05 minute P M.

21. I hereby certify that I attended the deceased from April 26  
19 46 to May 5 19 46

that I last saw him or her alive on May 5 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death. Carcinoma of the uterus

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

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

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 W. M. Fitzgerald (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Avenue Date signed 5/6/46

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

17103

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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..... *Robert Wheeler* .....  
Licensed Embalmer No..... *2178* .....  
P. O. Address..... *Spencer, Ma* .....

**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.**