

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18314**

FILED MAY 17 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4034**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**

(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **CITY HOSPITAL**
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **MARY DAHL**

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 _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased **MARCH 22 1860**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
86	1	11	hr. min.

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

10. Usual occupation **HOUSEWIFE**

MOTHER FATHER

11. Industry or business _____

12. Name **JOHN SCHILLINGER U**

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

14. Maiden name **UNKNOWN**

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

16. (a) Informant **BERTHA FELR**

(b) Address **3630 MINNESOTA**

17. (a) BURIAL **(b) Date thereof** **MAY 6 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ST. MATTHEWS Cem.**

18. (a) Signature of funeral director **Thos. J. Kuter**

(b) Address **2906 GRAVOIS**

19. (a) MAY 2 1946 **(b) J. F. Beebeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**

(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **2632 LYNCH**
(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 **3**
year **1946** hour **3** minute **00 A.M.**

21. I hereby certify that I attended the deceased from _____, 19____, 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: **Fracture Right Hip**
Internal and External Wounds
Deceased fell to the floor
then having at 2632 Lynch
On March 24, 1946
Due to 700 G m

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence **March 24 1946**

(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?
Home
(Specify type of place) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

White at work? _____

23. Signature **Patrick C. Haylaw**
(M. D. or other)

Address **1300 Clark** Date signed **3-5-46**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

17130

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.....

Leo J. Budde

Licensed Embalmer No.....

3989

P. O. Address.....

St. Louis, MO

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.