

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH

21751

State File No. _____

FILED JUN 20 1946
318

Primary Registration District No. **1003**

Registrar's No. **5169**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(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 _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME CHARLES GAIRINGER

3. (b) If veteran, name war 770 3. (c) Social Security No. 491-14-7374

4. Sex Male 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 Aug. 5 1869
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 3
If less than one day _____ hr. _____ min.

9. Birthplace Fond du Lac Wis. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Candy maker

11. Industry or business Mfg Candy

MOTHER FATHER

12. Name Unknown 9

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 Mr. H. B. Tietjen 1

(b) Address 2851 Indiana Av.

17. (a) Burial (b) Date thereof 6-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N. St. Marcus Cem

18. (a) Signature of funeral director Walt Bro. Lohs

(b) Address 2929 S. Jefferson Av.

19. (a) JUN 10 1946 (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 24-17
(If outside city or town limits, write "RURAL")
(d) Street No. 2851 Indiana Av. 9
(If rural, give location) 10
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8th
year 1946 hour 1:00 minute P M.

21. I hereby certify that I attended the deceased from 6/4/46
_____ 19 to 6/8/46 19
that I last saw him alive on 6/8/46 19
and that death occurred on the date and hour stated above.

Immediate cause of death Acute pyelonephritis
Non-calculous
Due to Nephroses
Due to Prostatic hypertrophy
Other conditions _____
(Include pregnancy within 3 months of death) 137
Major findings: _____
Of operations _____
Of autopsy As above

Duration

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) Method of injury _____
Signature [Signature] 1515 Lafayette 6/10/46
Address _____ Date signed _____

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

206930

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.....
.....
Licensed Embalmer No. 2117

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.