

No. 2
5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22096**
Registrar's No. **5714**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis, Mo.**
(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: **Barnes Hospital.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **22 days** (Specify whether years, months or days)
In this community **22 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **Madison 994**
(c) City or town **Collinsville**
(If outside city or town limits, write "RURAL")
(d) Street No. **409 West Main**
(If rural, give location) **NR. 11**
(e) Citizen of foreign country? (Yes or No) **2**
If yes, name country

3. (a) PRINT FULL NAME **Francis M. Pinter**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **27**
year **1946** hour **12** minute **45 a.** M.

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **John Pinter**
6. (c) Age of husband or wife if alive **52** years

21. I hereby certify that I attended the deceased from **June 6, 1946** to **June 27, 1946**
that I last saw her alive on **June 27, 1946**
and that death occurred on the date and hour stated above.
Immediate cause of death **Pulmonary embolus** Duration

7. Birth date of deceased **Aug 25th 1896**
(Month) (Day) (Year)
8. AGE: Years **49** Months **10** Days **2**
If less than one day hr. min.

Due to **Phlebothrombosis**
Due to

9. Birthplace **Troy Ills.,**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housework**

Other conditions **Adenocarcinoma of rectum**
(Include pregnancy within 3 months of death)

11. Industry or business **Own Home**
12. Name **Martin Arth Sr.,**
13. Birthplace **Madison Ills.,**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Keller**
15. Birthplace **Austria**
(City, town, or county) (State or foreign country)

Major findings:
Of operations **Adenocarcinoma of rectum and involvement of liver**
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER
16. (a) Informant **John Pinter**
(b) Address **Collinsville, Ills.,**
removal (b) Date thereof **6/28/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Collinsville, Ills.**

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?
(Specify type of place)
While at work? (e) Means of injury

18. (c) Signature of funeral director **Geo. M. Schraepfer**
(b) Address **Collinsville, Ills.,**
19. (a) **JUN 28 1946** **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

23. Signature **R. Bradley** (M. D. or D.O.)
Address **Barnes Hospital** Date signed **6/27/46**

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

20965

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 M. Knaeppel*

Licensed Embalmer No. **1598**

P. O. Address **Collinsville, Ills.,**

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.