

**FILED** SEP 16 1946  
318

1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
2835 S. Jefferson 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000

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

(d) Street No. 2835 S. Jefferson 249  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Carl H. Soeffner

3. (b) If veteran, name war NONE

3. (c) Social Security No. 494-01-1951

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 3  
year 1946 hour 1 minute P.M.

21. I hereby certify that I attended the deceased from July 2, 1946 to September 3, 1946  
that I last saw him alive on August 31, 1946  
and that death occurred on the date and hour stated above.

4. Sex M Color or race W

5. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wife Lydia Soeffner

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased: July 22 1888  
(Month) (Day) (Year)

Immediate cause of death: Coronary Thrombosis 1 day

Due to cardio-vascular Renal Diseases 2 yrs

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

**8. AGE:**

Years	Months	Days	If less than one day
<u>58</u>	<u>1</u>	<u>13</u>	_____ hr. _____ min.

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Inspector

11. Industry or business City Water Dept.

**MOTHER FATHER**

12. Name UNKNOWN

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 Lydia Soeffner

(b) Address 2835 S. Jefferson

17. (a) CREMATION (Burial, cremation, or removal)

(b) Date thereof Sept. 6, 1946  
(Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director With Bros. & Co.

(b) Address 2529 S. Jefferson Ave.

19. (a) SEP 5 1946 (Date received local registrar)

(b) [Signature] (Registrar's signature)

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 J.P. Keim M.D. (M. D. or other)

Address 2730 McNAIR AVE Date signed 9/4/46

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

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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

*A M Davis*

Licensed Embalmer No.

*374*

P. O. Address

*2929 Safe Person*

**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.**