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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

35162

FILED SEP 21 1946
#05557

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8816**

1. PLACE OF DEATH:

(a) County.....
(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.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Richmond Heights,**
(If outside city or town limits, write "RURAL")
(d) Street No. **7200 West Park Avenue**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

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3. (a) PRINT FULL NAME **HENRY GOTTFRIED**

3. (b) If veteran, name war **No.** 3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Clara Belle Smith Dec'd 11/30/34** 6. (c) Age of husband or wife if alive **11/30/34** years

7. Birth date of deceased **May 7, 1863**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 5 7 hr. min.

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

10. Usual occupation **Retired Salesman.**

11. Industry or business **J. Kennard Carpet Co.**

MOTHER FATHER

12. Name **Conrad Gottfried**

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

14. Maiden name **Eva Schallhaus**

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

16. (a) Informant **Mrs. C. Maxwell,**

(b) Address **7200 West Park Avenue, Richmond Heights**

17. (a) **Burial** (b) Date thereof **10/15/46 Mo.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Cemetery**

18. (a) Signature of funeral director **Robert J. Ambruster, Inc.**

(b) Address **Clayton Rd. at Concordia Lane**

19. (a) Date received from Registrar **SEP 14 1946** (b) Registrar's signature **J. F. Budeck**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **14th**
year **1946** hour **8:32** minute **A** M.

21. I hereby certify that I attended the deceased from **10/9/46** to **Oct. 14th** 19. **46**
that I last saw him **im** alive on **Oct. 14th** 19. **46**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Thrombosis** Duration **5 days.**

Due to **Arteriosclerotic Heart Disease**

Due to

Other conditions (Include pregnancy within 3 months of death) **93**

Major findings: Of operations

Of autopsy

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?

(Specify type of place) While at work **Cherry Brown, M.D.** (Specify type of injury)

23. Signature **1515 Lafayette** 10/15/46 (her)

Address

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

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 Arnold W. Schoene
Licensed Embalmer No. 3864
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.