

FILED NOV 25 1946

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9580**

1. PLACE OF DEATH:

(a) County _____
(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:
4333 Gertrude Ave.
(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 **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4333 Gertrude Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Sophie J. Roth**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Late John** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec. 14 1882**
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
63	10	25	hr. _____ min. _____

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

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Unknown Kriechelt**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Milton Roth**

(b) Address **4333 Gertrude Ave.**

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

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

18. (a) Signature of funeral director **Kriegshauser Und. Co.**

(b) Address **4228 So. Kingshighway Bl.**

19. (a) **NOV 9 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **9th**
year **1946** hour **10:45** minute _____ P.M.

21. I hereby certify that I attended the deceased from **Nov. 3**
1946 to **Nov. 8** 19**46**
that I last saw her alive on **Nov. 8** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **myocardial insufficiency** Duration _____

Due to **1) Hypertensive Heart Disease**

Due to **2) Coronary Heart Disease, Chronic**

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.

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 _____

23. Signature **Robert Potashnick** (M. D. or other) _____

Address **634 N. Grand** Date signed **11/9/46**

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

MOTHER FATHER

1971
Mrs. Stovesand
101

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..... *Richard W. Stovesand*
Licensed Embalmer No..... *4007*
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.