

No. 2  
2-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

392747

5 FILED NOV 25 1946  
318

State File No. ....

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 9583

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: St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location) Memorial  
(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 \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 809 Allen Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HELEN (ZUPETZ) ZUPEZ  
3. (b) If veteran, name war. --- 3. (c) Social Security No. ---

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 8th  
year 1946 hour 1:35 minute P M.  
21. I hereby certify that I attended the deceased from 9/11/46  
Nov. 8th, 1946  
to Nov. 8th, 1946  
that I last saw her alive on Nov. 8th, 1946  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

4. Sex female / 5. Color or race white  
6. (a) Single, widowed, married, divorced, widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 5th 1864  
(Month) (Day) (Year)

Arteriosclerotic Heart Disease  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 82 Months 7 Days 3 If less than one day hr. min.  
9. Birthplace Austria (City, town, or county) (State or foreign country)  
10. Usual occupation At home

PHYSICIAN  
Underline the cause to which death should be charged statistically.

MOTHER, FATHER

11. Industry or business \_\_\_\_\_  
12. Name John Karnitsching  
13. Birthplace Austria (City, town, or county) (State or foreign country)  
14. Maiden name Anna Miller  
15. Birthplace Austria (City, town, or county) (State or foreign country)

16. (a) Informant John A. Zupetz  
(b) Address 6411 Woodbine Court  
17. (a) burial (b) Date thereof 11-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Old SS Peter & Paul  
18. (a) Signature of funeral director Ziegenhein Bros.  
(b) Address 6409 Gravois Ave.  
19. (a) NOV 9 1946 (b) J. F. Bredeek  
(Date received local registrar) (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 W. H. Fitzgerald (M.D. or other) 1515 LAFAYETTE 11/9/46  
Address Date signed

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 *Homer W. Smith*

Licensed Embalmer No. *3882*

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.**