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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **12362**
Registrar's No. **10519**

Registration District No. **318**
Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
5026 Nottingham
(If not in hospital or institution, write street number or location)

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

In this community Family
years, months or days

3. (a) PRINT FULL NAME Magdaline Fiedler

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife George F. Fiedler 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 13, 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>2</u>	<u>23</u>	_____ hr. _____ min.

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

10. Usual occupation At home

MOTHER FATHER

11. Industry or business _____

12. Name Not known

13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant William Fiedler

(b) Address 913 Wilmington

17. (a) Burial (b) Date thereof 12/9/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebañon Cem

18. (a) Signature of funeral director J. L. Ziegenhein & Sons

(b) Address 7027 Gravois Ave

19. (a) DEC 9 1946 (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

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. 5026 Nottingham
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Decemben day 6th,
year 1946 hour 10 minute 20 P. M.

21. I hereby certify that I attended the deceased from 5-14-46 to 12-6-46;
that I last saw her alive on 12/16/46, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
acute coronary thrombosis
chronic supraventricular
irregularly irregular
atrial fibrillation

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? _____

23. Signature _____ (Specify type of place) _____
While at work? _____ Means of injury _____

Address 4523 S. Kingshighway Date signed 12/16/46

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 *Francis J. Owens*

Licensed Embalmer No. *7245*

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.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME

Magdaline Trudler

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife George

6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:

Years 70

Months _____

Days _____

If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Brodeck (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

PLEASE PRINT CLEARLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

42362

NEW YORK

2600
7/6