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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6255

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 1180

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

1. PLACE OF DEATH:

(a) County MISSOURI

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

(c) Name of hospital or institution: ST. ANTHONY'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 WEEKS (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. 3438 IOWA
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME MYRTLE MARY FELDMANN

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 MARRIED

6. (b) Name of husband ~~or wife~~ HARRY

6. (c) Age of husband ~~or wife~~ if alive 56 years

7. Birth date of deceased SEPTEMBER (Month) 6 (Day) 1896 (Year)

8. AGE: Years 50 | Months 4 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name ALFRED BROOKSHIRE
13. Birthplace MO. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name DORA GUHL
15. Birthplace MO (City, town, or county) (State or foreign country)

16. (a) Informant HARRY FELDMANN
(b) Address 3438 IOWA

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 6 1947 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ NEW SS. P. & P. CEM.

18. (a) Signature of funeral director Thomas Kutis & Son
(b) Address 2906 GRAVOIS

19. (a) FEB 4 1947 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 3
year 1947 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 20, 1947, to ~~Jan~~ Feb 3, 1947
that I last saw her alive on Feb 3, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Paralytic Ileus.	1-26-47
Due to	
Due to	
Other conditions: Chronic Cholelithiasis. Hydrops of GB ? (Include pregnancy within 3 months of death)	

Major findings:
Of operations as above
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 [signature] (M. D. ~~or other~~)
Address 5417 So Grand Date signed 2/4/47

(Licensed Embalmer's Statement on Reverse Side)

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 Leo J. Rudde

Licensed Embalmer No. 3989

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.

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M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1180

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:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

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

3. (a) PRINT FULL NAME Myrtle M. Feldmann

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 6 1899
(Month) (Day) (Year)

8. AGE: Years 50 Months Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January Day
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
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? (Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY

S-6255