

LED MAR 11 1948 18

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. _____

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:
Lutheran Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 1/2 weeks
(Specify whether weeks, months or days)

In this community 68 years
(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. 3510 Itaska Avenue
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Lydia Stelloh

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 Widowed

6. (b) Name of husband or wife Edward W. Stelloh

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

7. Birth date of deceased April 4, 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>10</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Unknown Laughlin

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

14. Maiden name Henrietta Unknown

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

16. (a) Informant Miss Irma Stelloh

(b) Address 3510 Itaska Avenue

17. (a) Burial (b) Date thereof March 1, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Our Redeemer Luth. Cemetery

18. (a) Signature of funeral director Beiderwieden F. H., Inc.

(b) Address 1936 St. Louis Avenue

19. (a) MAR 1 1948 (b) J. F. Bradech
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26,
year 1947 hour 9: minute 20 A. M.

21. I hereby certify that I attended the deceased from June 1946 to Jan 26 1947
that I last saw him alive on Jan 26 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Asenium
Duration 3 days

Due to Chronic nephritis

Due to Bright disease

Other conditions: 131
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: 131
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? _____

While at work? _____ (Specify type of place) _____
(c) Means of injury 0

23. Signature A. M. Drane (M. D. or other) MD

Address 2657 Guley Date signed 4/22/47

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

MOTHER FATHER

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..... *Glew W. Hat*

Licensed Embalmer No..... *0 3737*

P. O. Address..... *1926 St. Louis Ave*

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.