

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7456
Registrar's No. 426

Registration District No. 317 Primary Registration District No. 6076

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

1. PLACE OF DEATH: ST. LOUIS
(a) County ST. LOUIS
(b) City or town Pine Lawn, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Shamrock Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks (Specify whether
In this community 40 yrs.
years, months or days)

3. (a) PRINT FULL NAME Margaret Preisack
(b) If veteran, name war _____ (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 Peter Preisack
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased November 24th, 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 3 0 hr. 8 min.

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name Peter Michael
13. Birthplace Europe
14. Maiden name Not known
15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant George Preisack

(b) Address 4634 Oldenburg Ave.

17. (a) Burial (b) Date thereof 2/27/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N. S. S. Peter & Paul

18. (a) Signature of funeral director J. L. Ziegenhein & Sons
(b) Address 7027 Gravois Ave.

19. (a) 2-27-47 (b) Ruth J. Allen, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town St. Louis Gardenlee 0
(If outside city or town limits, write "RURAL")
(d) Street No. 4634 Oldenburg Ave.
(If rural, give location)
(e) Citizen of foreign country? No! (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24th,
year 1947 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from February 1, 1946 to February 24, 1947;
that I last saw him alive on February 17, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis with decompensation Duration 3 yrs
Due to Hypertension 93d 5 yrs
arterio sclerosis 5 yrs

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? _____

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

23. Signature Lewis Stittmann (M. D. or other) MD
Address 8231 Clayton Rd Date signed 2/24/47

APR 10 1947

APR 9 1947

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 *W. J. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7027 Gravoia*

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.