

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10781

State File No. 2877

FILED MAR 31 1947
318

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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:
ENROUTE CITY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 44 YRS. (Specify whether 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") 1317

(d) Street No. 1857 1/2 S. (If rural, give location) 9th 9

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MARGARET KREITZ EGLER

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 WIDOW

6. (b) Name of husband or wife _____

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

7. Birth date of deceased MAY 28 1877
(Month) (Day) (Year)

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

69 9 15 hr. min. 4

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

10. Usual occupation WIDOW

11. Industry or business AT HOME

12. Name JOHN SCHNEIDER

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

14. Maiden name UNKNOWN

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

16. (a) Informant MARGARET SCHOLLER

(b) Address 34 55 S OREGON

17. (a) BURIAL (b) Date thereof MAR. 19, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLD S.S. PETER + PAUL

18. (a) Signature of funeral director Thomas Kretz, 1 Son

(b) Address 2906 GRAVOIS

19. (a) MAR 18 1947 (b) J. F. BRIDGEMAN
(Date buried local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR. day 15
year 1947 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 9, 1935
to Mar 15, 1947
that I last saw her alive on Mar 31, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration 10 yrs

Cardiovascular and systemic
@E hypertension - angina
pectoris

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 121

Major findings: _____

Of operations none

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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 J. F. Bridgeman (M. D. or other) 0

Address 380 S. Wilmington Ave. Date signed 3/17/47

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.....

Leo J. Budde

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.