

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25466**
 Registrar's No. **7462**

Registration District No. _____ Primary Registration District No. **1075**

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

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:
DePaul Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Four days**
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. L**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4004 Lee Ave.**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Theodore F. Deters**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **499-28-8392**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Divorced**
 6. (b) Name of husband or wife **Minnie Deters**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **July 22, 1877**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	0	8	_____ hr. _____ min.

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

10. Usual occupation **Retired Postal Clerk**

MOTHER FATHER

11. Industry or business _____

12. Name **Herman Deters.**

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

14. Maiden name **Catherine Schwarzenhanl**

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

16. (a) Informant **Anna Preut**
 (b) Address **4027 Warne Ave.**

17. (a) **Burial** (b) Date thereof **8/2/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **[Signature]**
 (b) Address **2117 E. Grand Blvd.**

19. (a) **AUG 1 1947** (b) **J. F. Pradeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30**
 year **1947** hour **11** minute **10 P. M.**

21. I hereby certify that I attended the deceased from **May 1 - July 30, 1947**
 that I last saw him alive on **July 30, 1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Hemorrhage
(left Cerebrum)

Due to _____

Due to _____

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

Major findings:
 Of operations _____
83

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)
 (c) Manner of injury _____

23. Signature **[Signature]** (M. D. or other) _____
 Address **2117 E. Grand Blvd.** Date signed **8/1/47**

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.....

Frank A. Moore

Licensed Embalmer No.....

3041

P. O. Address.....

2117 E Grand

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.