

No. 300
10-47
17-39
13906

UNITED STATES OF AMERICA
STANDARD CERTIFICATE OF DEATH

State File No. 58245
Registrar's No. _____

FILED MAR 8 1948
Registration District No. 377

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
5008 Heege Rd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis ⁹⁶

(c) City or town St Louis County Rural ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. 5008 Heege Rd ⁵
(If rural, give location)

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

3. (a) PRINT FULL NAME Christine Sprengnether

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 34 day 11
year 1948 hour 9:15 minute _____ A.M.

21. I hereby certify that I attended the deceased from Oct. 16
1947 to 3-1 1948
that I last saw her alive on 2-28 1948
and that death occurred on the date and hour stated above.

4. Sex F / W

5. Color or race W

6. (a) Single, widowed, married, divorced Mar

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: 4 6 1876
(Month) (Day) (Year)

Immediate cause of death _____
Myocarditis

Due to arteriosclerosis ^{3 year}

Due to 93d ^{3 year}

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

8. AGE: Years 71 Months 11 Days 24
If less than one day _____ hr. _____ min.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Victor Storck 4

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Christine Sprengnether

(b) Address 5008 Heege

17. (a) Burial (b) Date thereof 3 4 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS Peter Paul Cem Wingbermuehle

18. (a) Signature of funeral director _____

(b) Address 3819 S Grand

19. (a) 3-3-48 (b) Carl R. Slapoff
(Date received local registrar) (Registrar's signature)

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? (1)

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

23. Signature M. R. Wilucki (M. D. or other) M.D.
Address 830 1/2 9th Ave Date signed 3-2-48

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

Ronald O. Yahrke

Licensed Embalmer No..... *3917*

P. O. Address..... *St. Louis*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *March*Registration District No. *317*Primary Registration District No. *6076*Registrar's No. *582*

1. PLACE OF DEATH:

(a) County *St Louis*
(b) City or town *Rural*
(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 _____)

In this community _____
years, months or days3. (a) PRINT FULL NAME *Christine Sprengel*

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 _____ year

7. Birth date of deceased *April* (Month) *11* (Day) *1948* (Year)8. AGE: Years *21* Months *11* Days *11* (If less than one day) _____ hr. _____ min.

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

10. Usual occupation *Submarine*

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (c) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* /
year *1948* hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____
to _____, 19 _____that I last saw him _____ 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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

7445