

No. 300
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5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH 100's

State File No. _____
Registrar's No. 8869

Registration District No. 318
Primary Registration District 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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County over 17
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3810 Folsom Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CAROLINE WATCHINGER
3. (b) If veteran, name war no
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 9th
year 1948 hour 11 minute 15 P. M.

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Joseph
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 26, 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 25, 1948, to Oct 9, 1948, that I last saw him alive on Oct 9, 1948, and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months 0 Days 13
If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral thrombosis Duration 14 days

9. Birthplace New Memphis, Illinois
(City, town, or county) (State or foreign country)

Due to _____
Due to _____

10. Usual occupation Hw

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

11. Industry or business _____

Major findings: _____
Of operations _____
Of autopsy _____

MOTHER FATHER { 12. Name William Peters
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Elizabeth Tilker
(b) Address 3810 Folsom

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

17. (a) Burial (b) Date thereof Oct. 13-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery

(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)

18. (a) Signature of funeral director [Signature]
(b) Address 3029 Lafayette Ave.

While at work? _____ (e) Means of injury 0

19. (a) OCT 13 1948 (Date received local registrar)
[Signature] (Registrar's signature)

23. Signature [Signature] (M. D. or other) MD
Address 2701 Brandel Sq Date signed 10-11-48

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

over

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.....

David Paul Fossow

Licensed Embalmer No. *4242*

P. O. Address. *3029 Lafayette*

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.