

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41256**
Registrar's No. **11354**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days ✓
(Specify whether years, months or days)

In this community 35 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 4131 Westminster Memorial
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM BARTELS

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased September 16th, 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>3</u>	<u>7</u>	hr. min.

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

10. Usual occupation laborer

11. Industry or business unemployed

12. Name William Bartels

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

14. Maiden name Louisa unknown

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical Board (b) Date thereof DEC 31 1948
(Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation Rowland Mortuary Service

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) DEC 31 1948 (b) J.B. Lacoste
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23rd
year 1948 hour 6 minute 04 A.M.

21. I hereby certify that I attended the deceased from 12/2/48
_____ 19____, to Dec. 23rd 19 48

that I last saw him alive on Dec. 23rd 19 48
and that death occurred on the same day and hour stated above.

Immediate cause of death Tobacco pneumonia Duration _____

Due to Hypertensive Cardiovascular disease

Due to _____

Other conditions 108
(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? no (Specify type of place) _____
(c) Means of injury car

23. Signature 1515 Lafayette 12/23/48
(Date received local registrar)

Address _____ Date signed _____

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.....

Licensed Embalmer No.....

P. O. Address.....

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.