

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6722**  
Registrar's No. **1928**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>000</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. Louis</b>	
c. LENGTH OF STAY (in this place) <b>1 Day</b>		d. STREET ADDRESS (If rural, give location) <b>3156 N 14 ST.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hosp</b>			

3. NAME OF DECEASED (Type or Print) <b>Mary</b>		a. (First)		b. (Middle)		c. (Last) <b>Stempfel</b>		4. DATE OF DEATH <b>FEB 26 1949</b> (Month) (Day) (Year)							
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW 2</b>		8. DATE OF BIRTH <b>Nov 27-1891</b>		9. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR Months Days		IF UNDER 4 WKS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Austria</b>				12. CITIZEN OF WHAT COUNTRY? <b>Austria</b>			

13a. FATHER'S NAME <b>Frank Hilttenfeldt</b>			13b. MOTHER'S MAIDEN NAME <b>Catherine Keiner</b>			14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Marie Hille</b> ADDRESS <b>1574 Carter</b>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arterio Sclerosis</b>							
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral apoplexy</b>						<b>24 hours</b>	
		DUE TO (c) <b>gla</b>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>334X</b>							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>334X</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **Dec 28, 1948** to **Feb 26, 1949**, that I last saw the deceased alive on **Feb 21, 1949** and that death occurred at **830A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>R. J. Stenneger</b> (Degree or title)		23b. ADDRESS <b>539 N Grand</b>		23c. DATE SIGNED <b>Feb 26 1949</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>March 1, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		24d. LOCATION (City, town, or county) (State) <b>ST. Louis MO.</b>	
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DATE REC'D BY LOCAL REG. <b>FEB 27 1949</b>		REGISTRAR'S SIGNATURE: <b>J. B. Faraker</b>		FUNERAL DIRECTOR'S SIGNATURE <b>Edward D. Koch</b> ADDRESS <b>4504 S. 4th - 3516 N 14 ST.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Wm*

**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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Ronald O. Zinke*

Licensed Embalmer No. *3917*

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.