

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39058**
9661
Registrar's No. _____

105233

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 20 3906 N. 23rd, Street, 7,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			
3. NAME OF DECEASED a. (First) KATIE b. (Middle) T. c. (Last) METZ		4. DATE OF DEATH (Month) (Day) (Year) November 8th, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 21st, 1871
9. AGE (In years last birthday) 78		10. UNDER 1 YEAR (Months) (Days) 5 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Frederick Tellkamp		13b. MOTHER'S MAIDEN NAME Dora Hustedt	14. NAME OF HUSBAND OR WIFE Late Robert F. Metz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elliott W. Metz, 3021 Arlmont Dr., Bel Nor
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stroke ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Circulatory failure DUE TO (c) Hemorrhagic Pancreatitis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) 128
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? 5870
22. I hereby certify that I attended the deceased from 11/6/49, 19 to 11/8/49, 19 , that I last saw the deceased alive on 11/8/49, 19 , and that death occurred at 11:30am , from the causes and on the date stated above.			
23a. SIGNATURE Ralph Berg, Jr. M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 11/8/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/11/49	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	24d. LOCATION (City, town, or county) (State) Saint Louis, Missouri
DATE REC'D BY LOCAL REG. NOV 9 1949	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F. Feutz, 4828 Natural Bridge Blvd.	

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

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 Ralph E. Leiders.....

Licensed Embalmer No. 4275.....

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.