

FILED JAN 18 1955

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43566**  
Registrar's No. **11686**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>11686</b>	
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. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>16 weeks</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>				7. STREET ADDRESS (If rural, give location) <b>5915 Summit Place</b> <b>2079</b>			
3. NAME OF DECEASED (Type or Print) <b>Delia</b>		a. (First) <b>M</b>		b. (Middle) <b>Feldmann</b>		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 21 1954</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>July 16, 1899</b>		9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Directors Distributors</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>August Kittenbrink</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Bohenkamp</b>		14. NAME OF HUSBAND OR WIFE <b>Walter C. Feldmann</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mr. Walter C. Feldmann, 5915 Summit Place</b>			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>myeloma of spinal canal</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>myeloma of spinal canal</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)			
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? <b>193x</b>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>3:45 a. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Kathleen Woadley R.N.</b> (Degree or title)				23b. ADDRESS <b>6 Hampton Village Pl.</b>		23c. DATE SIGNED <b>12/22/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Dec. 24, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>DEC 23 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave.</b>			

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.....  
Signature of Student Embalmer

Signed.....  
*Oliver W. Vay*

Licensed Embalmer No. *373*

P. O. Address *S. Power*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

**If this body is not embalmed, fact should be so stated above.**