

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AN 26 1934

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

41588

1. PLACE OF DEATH

County ..... Registration District No. 791  
Township ..... Primary Registration District No. 0000  
City St. Louis (No. 6647, Hoffman Ave.) St. .... Ward .....

File No. ....  
Registered No. 10608  
St. .... Ward .....

2. FULL NAME

Susanna Staffel  
(a) Residence, No. 6647 Hoffman Ave. St. 3 Ward. ....

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Late James Staffel  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 21, 1874  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
59 8 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation. ....

12. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Austria Hungary

FATHER 13. NAME Michael Babek

14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Austria Hungary

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Austria Hungary

17. INFORMANT Joseph Staffel  
(ADDRESS) 6647 Hoffman Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mo. Crematory DATE 12-11 1933

19. UNDERTAKER Francis J. Martynovic  
(ADDRESS) 4227 So. Broadway

20. FILED 11 1933 J. F. Babek Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-9 1933

22. I HEREBY CERTIFY, That I attended deceased from Dec 1 1933 to Dec 9 1933  
I last saw h. or alive on Dec 8 1933 Death is said to have occurred on the date stated above, at 12:30 a.m.  
The principal cause of death and related causes of importance were as follows:

Bronchial Asthma Date of onset 1930  
93C (non-tubercular)  
112  
Other contributory causes of importance: Chronic myocarditis 1933

Name of operation no Date of .....  
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify .....

(Signed) L. W. Scherman, M. D.  
(Address) 2919 S. Kingshighway Blvd.

ST. LOUIS, MO.

