

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

35664
Do not use this space.

NOV 15 1937

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Registered No. 9241

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City St. Louis..... (d) Street No. City Hospital No. 1..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
C. 9223

2. PRINT FULL NAME

Maude Stevens
(a) Residence, No. 2015 South 3rd St. 23 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF Alfred Stevens
(OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 20, 1873
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 10 10
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. hwk
9. Industry or business in which work was done, as saw mill, bank, etc. at home
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/30/37, 19...
22. I HEREBY CERTIFY, That I attended deceased from 9/24/37, 19... to 9/30/37, 19...
I last saw her alive on 9/30/37, 19... Death is said to have occurred on the date stated above, at 8.20 p
The principal cause of death and related causes of importance were as follows:

Encephalitis (acute, epidemic)

Date of onset

Other contributory causes of importance:

11

Name of operation..... Date of.....
What test confirmed diagnosis?..... 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?
If so, specify

(Signed) Charles M. Jester, M. D.
(Address) City Hospital No. 1

12. BIRTHPLACE (CITY OR TOWN) Waukon Jct.
(STATE OR COUNTRY) IOWA
13. NAME Manfred Flack
14. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
15. MAIDEN NAME ? Rose Flack
16. BIRTHPLACE (CITY OR TOWN) ? Unknown
(STATE OR COUNTRY)
17. INFORMANT Hsp Info M. Kent
(ADDRESS) City Hosp #1
18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Trinity Cem. DATE Oct. 4, 1937
19. FUNERAL DIRECTOR C. Hoffmeister U.L. Co.
(ADDRESS) 7814 So. Bixby St. Louis, Mo.
20. FILED OCT 2 1937 J. Bredeck
Local Registrar.

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.

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STATEMENT BY LICENSED EMBALMER

I, George W. Hoffmeister, Licensed Embalmer No. 2426

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Leo J. Budde, L. E. #3989

L. E. and Linus C. Hoffmeister, L. E. #3871

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed

George W. Hoffmeister

Licensed Embalmer No. 2426

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.)