

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.

REC'D FEB 10 1939

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

791  
1008

461  
Do not use this space.

461

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City..... or..... (d) Street No. 2018 MALLINCKRODT 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.

2. PRINT FULL NAME EDWARD OPPENLANDER

(a) Residence, No. 2018 MALLINCKRODT ST. St. 36 (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 MALE	4. COLOR OR RACE WHITE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC. 11, 1894		
7. AGE	YEARS 44	MONTHS 1
		DAYS 2
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. MACHINE HAND	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS, MO.	
	13. NAME WILLIAM OPPENLANDER	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) PENN.	
MOTHER	15. MAIDEN NAME MARY DE GROTE	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY	
	17. INFORMANT MARY OPPENLANDER (ADDRESS) 2018 MALLINCKRODT ST	
	18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY CEMETERY DATE JAN 16 1939	
	19. FUNERAL DIRECTOR (NAME) Goodhart & Goodhart (ADDRESS) 2228 St. Louis Ave	
	20. FILED JAN 14 1939 J. F. Bruleck Local Registrar	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JANUARY 13<sup>TH</sup>, 1939

22. I HEREBY CERTIFY, That I attended deceased from JULY 5<sup>TH</sup>, 1937, to JANUARY 13<sup>TH</sup>, 1939. I last saw h. i. m. alive on JAN. 12<sup>TH</sup> (9:30 PM) 1939. Death is said to have occurred on the date stated above, at 3:55 AM. The principal cause of death and related causes of importance were as follows:

Cardiac Hypertrophy (Dilated Right Atricle and Both Ventricles Left Atricle and Aortic Arch Dilated) (No Aneurism)

Other contributory causes of importance: CHRONIC NEPHRITIS

Name of operation..... Date of.....  
What test confirmed diagnosis? X-RAY 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) H. J. Fibronczyk M.D.  
(Address) 3621 No 20<sup>TH</sup> STR. ST. LOUIS MO

**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.....

*Charles Goodhart*  
.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed *Charles Goodhart*  
.....  
Licensed Embalmer No. *2777*  
.....

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, above space should be left blank.**