

DECEMBER 2 1939

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

11241
Do not use this space.

1. PLACE OF DEATH *Jefferson*

(a) County *Jefferson* Registration District No. *423*

(b) Township *Rock* Primary Registration District No. *5578* Registered No. *13*

(c) City _____ (d) Street No. _____

(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 *SADIE STAHL*

(a) Residence, No. *Barnhart mo* St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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 *Single*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 26-1875*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *63 10 16*

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *House Work*

9. Industry or business in which work was done, as 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) *Sevely mo.*

FATHER 13. NAME *John Stahl*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

MOTHER 15. MAIDEN NAME *Ann Rabe*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 12th 1939*

I HEREBY CERTIFY, That I attended deceased from *Jan 31 1939* to *3-12 1939*

last saw him alive on *3/12/39*, 19____. Death is said to have occurred on the date stated above, at *3 P* m.

The principal cause of death and related causes of importance were as follows:

*Apoplexy
Supine at middle
meningeal*

Other contributory causes of importance: *Senility*

Name of operation *Clinical* Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) *Phil J. Kirk* M. D.

(Address) *384*

17. INFORMANT *L. F. Yeager*
(ADDRESS) *St. Louis mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Immmanuel Lutheran Cemetery* DATE *March 15 1939*

19. FUNERAL DIRECTOR *Heilighs Funeral Home*
(ADDRESS) *St. Louis mo.*

20. FILED *Mar 15 1939* *Phil J. Kirk*
Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

V. S. NO. 2
507-720-37
I X12004

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, Frederick Heiligtag, Licensed Embalmer No. 3150

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed Frederick Heiligtag
Licensed Embalmer No.

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.)