

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

19867
Do not use this space.

1. PLACE OF DEATH

(a) County Saint Louis Registration District No. 784
 (b) Township Carondelet Primary Registration District No. 200
 (c) City Missouri (d) Street No. Veterans Hospital St. Unkn.
 (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 Paul F. Staetter

(a) Residence, No. 3000 Park Avenue, Saint Louis, St. Missouri
 (Usual place of abode, if no street address, write county of city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Lillian Staetter

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 1, 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 3 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Optician
 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) Saint Louis, (STATE OR COUNTRY) Missouri.

13. NAME Frank Staetter
 14. BIRTHPLACE (CITY OR TOWN) Saint Louis (STATE OR COUNTRY) Missouri.

15. MAIDEN NAME Anna Wackerlin
 16. BIRTHPLACE (CITY OR TOWN) - (STATE OR COUNTRY) Switzerland

17. INFORMANT Clinical Clerk, V.A.F. Jefferson Barracks, Missouri.

18. BURIAL, CREMATION, OR REMOVAL PLACE Jefferson Barracks DATE 6-6-39

19. FUNERAL DIRECTOR (NAME) Thiephaus Martini (ADDRESS) 4228 North High in Ag

20. FILED JUN 3 - 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 20, 1939, to June 2, 1939

I last saw him alive on June 2, 1939. Death is said to have occurred on the date stated above, at 5:50P.m.
 The principal cause of death and related causes of importance were as follows:

Carcinoma of cecum, ileum and ascending colon. Date of onset Unkn.

Other contributory causes of importance: None.

Name of operation Laparotomy with re-section of cecum Date of 5-11-39
 by clinical man. and lab. 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 Yes
 (Signed) HARRY LEVINE, Chief Med. Off., M. D.
 (Address) V.A.F., Jefferson Barracks, Mo.

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.

46

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Erwin D. McDermott

Licensed Embalmer No. 3024

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1-2367160-Death
top. O. 6-6-39
19867
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township..... Primary Registration District No. 200 Registered No. 1009-
(c) City..... (d) Street No. Vets. Adm. Bldg. 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

(a) Residence, No. St. Louis Mo St. (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
62 3 1

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.....
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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 2 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of cecum, ileum and colon -
Primary site not #
Other contributory causes of importance:

Name of operation Laparotomy & Resection Cecum Date of 5-11-39
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? If so, specify.....
(Signed) Narry Levine L.M.D. M.D.
(Address) Jefferson Bldg.

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

