

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26916

State File No. \_\_\_\_\_

AUG 7 1939  
Registration District No. 107

Primary Registration District No. 200

Registrar's No. 1386

1. PLACE OF DEATH:  
 (a) County Saint Louis  
 (b) City or town Rural (Overland, MO)  
(If outside city or town limits, write "RURAL" and name of township)  
8824 Tudor Avenue  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community Seven years

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
 (c) City or town Rural (Overland)  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 8824 Tudor Ave  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Stella A. Weinbrenner 516  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 2  
 year 1939 hour 12 minute 10 a. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept. 6 1990  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 10,  
1937, to Aug 2, 1939;  
 that I last saw her alive on July 31, 1939;  
 and that death occurred on the date and hour stated above.

8. AGE: Years 48 Months 10 Days 26  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_ Duration 3/27/39  
Cerebral Hemorrhage  
 Due to Arterio Sclerosis  
 Due to Nephritis

9. Birthplace Saint Louis Missouri  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Clerk Retired

Other conditions \_\_\_\_\_  
(Includes pregnancy within 3 months of death)  
 Major findings: No Operation  
 Of operations \_\_\_\_\_  
 Of autopsy No autopsy

MOTHER FATHER  
 11. Industry or business Dry Goods  
 12. Name Charles J. Weinbrenner  
 13. Birthplace Bowling Green Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Delia Brennan  
 15. Birthplace New Orleans La.  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury? \_\_\_\_\_

16. (a) Informant's own signature Annie M. Stanton  
 (b) Address 8824 Tudor Ave.

23. Signature Herman Kloeber (M. D. or other) MD  
 Address 9621 Barksdale Rd Date signed 8/2/39

17. (a) Burial (b) Date thereof Aug. 4 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery  
 18. (a) Signature of funeral director Thos. J. Finnan  
 (b) Address 1519 South Grand Blvd.  
 19. (a) AUG 2 1939 (b) W. R. Meyer  
(Date received local registrar) (Registrar's signature)

1324

**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 me

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Thomas J. Finnan

Licensed Embalmer No. 1147

P. O. Address St. Louis

**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.**

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

Do not use this space.

26 916

**1. PLACE OF DEATH**

County St. Louis  
Township.....  
City..... (No. ....)

Registration District No. 784  
Primary Registration District No. 200

File No. 1386-  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Helen A. Steinbruner

(a) Residence, No. Westland St. .... 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W  
(Write the word)

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. or .....min.  
48 10 26

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
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)

MOTHER, FATHER  
13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. UNDERTAKER (ADDRESS)

20. FILED 19.....

Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 2 1934

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

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:

Cerebral hemorrhage Date of onset  
Arteriosclerosis  
Nephritis - Chronic

Other contributory causes of importance:

Name of operation..... 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?.....

If so, specify Herman K. Ducker M. D.  
(Signed) 921 Lockwood Rd. (Address)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified.

**TEMPORARILY**

S-26916

1937