

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF THE VIGILANCE 1939  
AUG 24 1939

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30256  
Registrar's No. 1509

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH: 2  
(a) County St. Louis  
(b) City or town St. John's Station  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Lifetime (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Ida Pflugbeil 421  
3. (b) If veteran, name war No 3. (c) Social Security No. No  
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Charles E. Pflugbeil 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 18, 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>1</u>	<u>7</u>	hr. _____ min.

9. Birthplace Lebanon Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Home  
(City, town, or county) (State or foreign country)

11. Industry or business \_\_\_\_\_  
12. Name Schmidt 9  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. A. H. Gunther  
(b) Address 2207 Ann Ave.,

17. (a) Burial (b) Date thereof Aug. 16, 39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthew's Cem.

18. (a) Signature of funeral director Wacker-Helderle  
(b) Address 2331 S. Broadway

19. (a) AUG 24 1939 (b) \_\_\_\_\_  
(Date of local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3408 Itaska Ave.,  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 23 day Aug.  
year 1939 hour 2:30 minute 10 M.  
21. I hereby certify that I attended the deceased from Jan 3  
1939, to Aug 23, 1939  
that I last saw her alive on Aug 1, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 7 months  
Due to \_\_\_\_\_  
Due to 131  
Other conditions Chronic Nephritis 7 months  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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) (s) Means of injury \_\_\_\_\_  
28. Signature Paul H. Kugelmann (M. D. or other) \_\_\_\_\_  
Address 3507 Oakwood Date signed 8/23

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**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.....

Licensed Embalmer No. *2645*

P. O. Address *St. Louis Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**