

USE WRITING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8175
Registrar's No. 423

Registration District No. 784 Primary Registration District No. 111

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 0 4338 Michigan Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME MARGARET THELE
(b) If veteran, name war _____ (c) Social Security No. 4-0-0

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 27
year 1940 hour 11 minute 40 P.M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William H.
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased October 2 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 9, 1940, to Feb 27, 1940, and that I last saw her alive on Feb 27, 1940, and that death occurred on the date and hour stated above.

8. AGE: Years 57 Months 4 Days 25
If less than one day hr. _____ min. _____

Immediate cause of death Chronic myocarditis with acute heart failure
Due to _____
Due to 50

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

Other conditions Carcinoma of Breast
(Include pregnancy within 3 months of death) 1 1/2 yr

10. Usual occupation At Home
11. Industry or business _____
12. Name Casimer Grosch
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Don't know
(City, town, or county) (State or foreign country)

Major findings: no
Of autopsy Carcinoma with metastatic Myocarditis
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature William H. Thele
(b) Address 4338 Michigan Ave.

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? _____

17. (a) Burial (b) Date thereof Mar. 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director J. H. Hubbs L. & W. Co.
(b) Address 2842 Meramed St.
19. (a) FEB 29 1940 (b) DR Meyer
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature J. H. Stevens (M. D.)
Address 8700 Grover Date signed 2-29-40

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.....

Robert F. Gebken

....., Registered Apprentice No. 187

working under my personal supervision.

Signed.....

Herman A. Gebken

Licensed Embalmer No. 2120

2842 Meramec St.

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.