

FILED APR 8 1940
Registration District No. 784

Primary Registration District No. 101

Registrar's No. 568

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.

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton Mo.
(c) Name of hospital or institution:
216 Meramec St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Wilhelmina Stauber
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Carl Stauber
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 10th 1857
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 10
If less than one day _____ hr. _____ min.

9. Birthplace Germany Foreign
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business Home

MOTHER FATHER
12. Name Conat
13. Birthplace Germany Foreign
(City, town, or county) (State or foreign country)
14. Maiden name Julia Brauch
15. Birthplace Germany Foreign
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Theophil Stauber
(b) Address 216 Meramec St.

17. (a) Burial (b) Date thereof March 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. John Cemetery

18. (a) Signature of funeral director W. H. Brown - Bone
(b) Address 326 N. 1st St. - St. Charles Mo.

19. (a) MAR 21 1940 (b) W. R. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Clayton Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 216 Meramec St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 20th
year 1940 hour 11 minute A. M.
21. I hereby certify that I attended the deceased from Feb 15, 1940
to Mar 20, 1940
that I last saw her alive on 2/20/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Duration 2 days
Due to _____
Due to R
Other conditions Cardiac Asthma
(Include pregnancy within 3 months of death)
Major findings: Emphysema
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?
76 While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature George Maden (M. D. or other) MD
Address 213 Central Clayton Date signed 3/24/40

95192

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.....

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.

of 7

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12922 -
Registrar's No. 568

Registration District No.

Primary Registration District No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(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 _____
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Wilhelmina Staesker

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-24-40 (b) _____ (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH Month Mar. Day 23 Year 40
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: By poststatic pneumonia (Bronchial)

Due to _____
Due to _____
Other conditions: Cardiac asthma
(Include pregnancy within 3 months of death)

Major findings: Emphysema 95%
Of operation _____
Of autopsy _____

Duration _____
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) (e) Means of injury _____

23. Signature James Meador (M. D. or other) _____

Address 2000 Date signed _____

SUPPLEMENTARY

1940

S-12323