

S. No. 2  
 -11-10-39  
 v. 5-17-39  
 I X21492

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

13022

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

MAY 15 1940

791

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. 3224

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Home of the Friendless  
 (If not in hospital or institution, write street number or location) 3  
 (d) Length of stay: In hospital or institution 35 yrs. (Specify whether  
 In this community 35 yrs.  
 years, months or days)

3. (a) PRINT FULL NAME Fannie Stein 350  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

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 November 9 1856  
 (Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Albert Stein

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

14. Maiden name UNKNOWN

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

16. (a) Informant Mrs. E. Jones

(b) Address 4431 S. Broadway

17. (a) Burial (b) Date thereof April 10, 40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. HOPE CEMETERY

18. (a) Signature of funeral director C. J. Hoffmann, D.O.

(b) Address 7814 S. Broadway

19. (a) APR 8 1940 (b) J. F. Buddick  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 15  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4431 S. Broadway  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7  
 year 1940 hour 2 minute 15 a. M.

21. I hereby certify that I attended the deceased from April 27, 1940, to April 7, 1940  
 that I last saw her alive on April 5, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death acute myocarditis 7 days

Due to Chronic Myocarditis 2 yrs  
Chronic Cholecystitis 1 yrs  
no stones

Other conditions Senility  
 (Include pregnancy within 3 months of death)

Major findings: 930  
 Of operations \_\_\_\_\_  
 Of autopsy no

Duration  
 7 days  
 2 yrs  
 1 yrs  
 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) no  
 (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 Chas. E. Aquidman (M. D. or other) MD  
 Address 3722 Washington Date signed 4/8/40

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

Oct 29 1904

**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 *Edwin H. Leubinger*

Licensed Embalmer No. *4049*

P. O. Address *646 S. Chippewa*

**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.**