

JUN 15 1940
Registration District No. 791

1003
Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8400 a Church Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 11 yr.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 8400 a Church Rd.
(If rural, give location) 58
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 14
year 40 hour 4 minute _____ P. M.
21. I hereby certify that I attended the deceased from 5-5-40
5-14-40, 1940 to 5-14-40, 1940

that I last saw her alive on 5-14-40
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocarditis
Chronic
Age

Due to _____
Due to _____

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

Major findings:
Of operations _____

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 W P Hamilton M.D. (M. D. or other)
Address 8363 Halls Ferry Date signed 5-14-40

8. (a) PRINT FULL NAME Mary Yordt 630

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 Yordt 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 2nd 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 3 12 hr. min.

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

10. Usual occupation housework

11. Industry or business _____

12. Name Friedensburg

18. Birthplace Denmark
(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 Mellum Yordt

(b) Address 8639 Oxford Lane

17. (a) burial (b) Date thereof Feb 17th 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethlehem Cemetery

18. (a) Signature of funeral director Diedrich Funeral Home

(b) Address 8319 Halls Ferry Rd.

19. (a) MAY 16 1940 (b) J. B. ...
(Date received local registrar) (Registrar's signature)

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.

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.....

J. G. Sullivan

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.