

JUN 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17027

State File No.

4505

Registration District No. 791

Primary Registration District No. 1003

Registrar's 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:
4223 A W. Evans Ave., 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community **60 Years** (Specify whether years, months or days)

8. (a) PRINT FULL NAME **Louise Stoehr,** 360

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **John Stoehr** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **October 4, 1844**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
95 **7** **17** hr. min.

9. Birthplace: **Germany** 6
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business.....

MOTHER FATHER { 12. Name **Schleicher**
13. Birthplace **Germany** 6
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Germany** 6
(City, town, or county) (State or foreign country)

16. (a) Informant **Anna Horstman**
(b) Address **4223 A W. Evans Ave.,**

17. (a) **Burial** (b) Date thereof **5-23-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Protchers Cemetery**

18. (a) Signature of funeral director **Wm. J. Paschedag**
(b) Address **2825 N. Grand Blvd.**

19. (a) **MAY 21 1940** (b) **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **4223 A W. Evans Ave.** 11
(If outside city or town limits, write "RURAL")
(d) Street No. **St. Louis,** -
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **21st**
year **1940** hour **3** minute **A.** M.

21. I hereby certify that I attended the deceased from **May 13, 1940**
19..... to **May 21** 19.....
that I last saw her alive on **May 20** 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
uremia
chronic nephritis
Due to **general arteriosclerosis** 2 yrs
Duration **6 days**

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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?

23. Signature **Arthur [Signature]** (M. D. or other) **M.D.**
Address **2202 University** Date signed **5/21/40**
While at work? (Specify type of place) (c) Means of Injury.....

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

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 Guy W. Wilkinson
Licensed Embalmer No. 3575
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.