

791

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

1003

State File No. 17261  
4739

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(c) Name of hospital or institution: 2936 Woodlee St. 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 50 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 10  
(d) Street No. 2936 Woodlee St.  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3. (a) PRINT FULL NAME ANGUST STAHLER 346  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. Unknown

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May 28 day 28 year 1940 hour 4:30 minute \_\_\_\_\_ M.

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife late Dorothy Stahler  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 21 - 1870

21. I hereby certify that I attended the deceased from May 23 1940 19 \_\_\_\_\_ to May 28 1940 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 9 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral Thrombosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Mascoutah Illinois  
10. Usual occupation Retired

Other conditions Right side non-deph-thertic result of chronic sore throat  
Major findings: No operations  
Of operations: apical blebs, small  
Of autopsy: none

MOTHER FATHER  
12. Name Phillip Stahler  
13. Birthplace Germany  
14. Maiden name Catharine Waser  
15. Birthplace Germany

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Freda Stahler  
(b) Address 2931 Woodlee St.  
17. (a) Burial (b) Date thereof May 31 - 1940  
(c) Place: burial or cremation Snydeys Cem  
18. (a) Signature of funeral director Hy. Lechner U.C.  
(b) Address 2223 St. Louis Ave  
19. (a) MAY 30 1940 (b) \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence no  
(c) Where did injury occur? none  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury fever  
23. Signature Wm. H. Harman M. D. or other) \_\_\_\_\_  
Address 2743 N. Grand Date May 30 1940

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

2345 N. Duane  
10-11

**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

*John P. Buchholz*

Licensed Embalmer No. 1670

P. O. Address. 2325 St Louis

**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.**