

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7061**

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:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 Days**
(Specify whether
In this community **60 years.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **24**
(If outside city or town limits, write "RURAL")
(d) Street No. **3728 Nebraska Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **60 years** years.

3. (a) PRINT FULL NAME **Mr. Jacob Waffenschmidt** **152**

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

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

6. (b) Name of husband or wife **Fredericka Waffenschmidt** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 13, 1860**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	4	6	hr. _____ min.

9. Birthplace **Baden-Koehl, Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Huckster - Retired**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Margaretha Unknown**

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

16. (a) Informant **Miss Mathilde Waffenschmidt**

(b) Address **3728 Nebraska Avenue**

17. (a) **Burial** (b) Date thereof **Aug. 21, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus**

18. (a) Signature of funeral director **Frederick Funeral Home**

(b) Address **1936 St. Louis Avenue**

19. (a) **AUG 21 1940** (b) **J. F. [Signature]**
(Date recorded by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19th**
year **1940** hour **1** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **8-10-40**
~~8-18~~ 19____ to **8-18** 19**40**
that I last saw him alive on **8-18** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death
Inoperated sigmoid hernia 8 days

Due to _____
Due to _____

Other conditions **Hepatitis Pneumonia**
(Include pregnancy within _____ months of death)
Broncho

Major findings:
Of operations _____
Of autopsy **127a**

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?

(Specify type of place) (e) Means of injury _____

23. Signature **Bernard Plach** (M. D. or other)
Address **3527 Osage, St. Louis Mo** Date signed **8-19-40**

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

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

Dr. Bernard Ploc
Grand t Oreg.

11-1

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.