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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27204

Registration District No. 791 Primary Registration District No. 1003 State File No. _____ Registrar's No. 7100

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Luthern Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 hrs.
In this community 11 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3932 Alberta
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Gertrude M. Fickinger 252

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

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

6. (b) Name of husband or wife Emil 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased August 9
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 0 13 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Martin Fouquet

13. Birthplace Europe
(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 Mr. Emil Fickinger

(b) Address 3932 Alberta

17. (a) Burial (b) Date thereof 8-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old SSPeter and Paul

18. (a) Signature of funeral director Oscar J. Hoffmeister

(b) Address 401 6 Chippewa

19. (a) AUG 23 1940 (b) J. F. Brudack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22
year 1940 hour 3.00 minute 9.00 A.M./P.M.

21. I hereby certify that I attended the deceased from Aug. 21st to Aug 22nd 1940;
that I last saw her alive on Aug. 26th 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration 1 da

Due to Hypertensive Heart Disease?

Due to _____

Other conditions Diabetes mellitus 3
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature Robert L. Drury M.D. (M.D. or other) M.D.
Address 3548 So. Grand Date signed Aug 24/40

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

MOTHER FATHER

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

Ernest W. Spillers

Licensed Embalmer No.

4080

P. O. Address

2747 Dunni

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.