

No. 2  
1-10-39  
17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30148

FILED OCT 25 1940 791

1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 7425

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town ST. LOUIS MO  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
8721 HALLSFERRY RD.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME MARY KALBFLEISCH

3. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 12 1857  
(Month) (Day) (Year)

8. AGE: Years 83 Months - Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name ?

13. Birthplace ?  
(City, town, or county) (State or foreign country)

14. Maiden name ?

15. Birthplace ?  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Brundage

(b) Address 8721 Hallsferry Rd.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept. 5 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation Concordia

18. (a) Signature of funeral director W. J. Brundage

(b) Address 1136 St. Louis Ave.

19. (a) SEP 4 1940 (Date received local registrar)

(b) J. Brundage (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 8721 HALLSFERRY RD.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 3ND  
year 1940 hour 10:30 minute 4 M.

21. I hereby certify that I attended the deceased from AUG. 1939  
\_\_\_\_\_ 19\_\_\_\_, to SEPT. 2, 1940, 19\_\_\_\_;

that I last saw h ER alive on SEPT. 2, 1940, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death DIABETES MELLITUS

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions NONE  
(Include pregnancy within 3 months of death)

Major findings: NONE

Of operations \_\_\_\_\_

Of autopsy NO

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? \_\_\_\_\_

23. Signature J. A. Van Schofer (M. D. or other) \_\_\_\_\_  
Address 6373 HALLS FERRY RD. CITY Date signed 9/3/40

Duration ONE YEAR

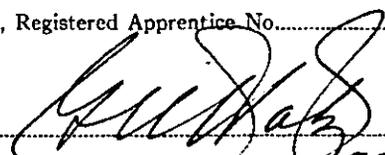
PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_  


Licensed Embalmer No. 2737

P. O. Address 1936 St. Venus Ct

**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.**