

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33874

Registration District No. 791

Primary Registration District No.

Registrar's No. 8521

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: Bethesda Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME Dolores Illert

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

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

7. Birth date of deceased October 6, 1938
(Month) (Day) (Year)

8. AGE: Years 2 Months 0 Days 9 If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

12. Name Walter P. Illert

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

14. Maiden name Margaret Hohner

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

16. (a) Informant Walter P. Illert

(b) Address 3103 Chippewa

17. (a) Burial (b) Date thereof 10/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O.S.S. Peter & Paul

18. (a) Signature of funeral director Wacker-Heldrich

(b) Address 1836 Broadway

19. (a) _____ (b) J. B. Bredbeck
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")
(d) Street No. 3103 Chippewa St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15
year 1940 hour 7 minute 25 A. M.

21. I hereby certify that I attended the deceased from July 24
1940, 19____, to Oct 15, 1940
that I last saw him alive on Oct 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Lymphatic Leukemia
Due to _____

Due to 720

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy Swollen liver spleen & kidneys

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature John Zaboraty (M. D. or other)

Address 534 N. Tager Date signed 10-16

Duration

3 months

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. *Frank J. Wilson*
9675

P. O. Address..... *St Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.