

791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

State File No. 40656

Registrar's No. 10427

Registration District No. _____

Primary Registration District No. _____

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:
5741 Holly Hills Ave
(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 HUBERT W. FLEISCHMANN

3. (b) If veteran, name war 110 3. (c) Social Security No. 110

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Anna Fleischmann 6. (c) Age of husband or wife if alive 74 years
 7. Birth date of deceased August 31 1856
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>3</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Unknow

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

14. Maiden name Otilia Traudt

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

16. (a) Informant's own signature H. Fleischmann

(b) Address 5741 Holly Hills

17. (a) Burial (b) Date thereof 12-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Central Und. Co. Inc

(b) Address 1841 Cass Ave

19. (a) DEC 19 1940 (b) J. H. Brudeck
(Date received local registrar) (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. 5741 Holly Hills Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 80 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
 year 1940 hour 8:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from FE13

_____ 1940, to Dec 10, 1940.

that I last saw him alive on Dec 15, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Constrictive heart failure Duration 9 mos.
Arteriosclerotic heart disease
 Due to arteriosclerosis ?
 Due to senility

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

Major findings: _____
 Of operations _____

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Jacob J. Shule (M. D. or other) M.D.

Address 4132 Adams Date signed 12-18-40

SEE WRITING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 J. G. Sullivan

Licensed Embalmer No. 1122

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.