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WITH UNFADING INK---THIS IS 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

43974
Do not use this space.

JAN 8 1941

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784

(b) Township St. Ferdinand 3 Primary Registration District No. 200 Registered No. 2373

(c) City St. Louis, Missouri (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME Sister Mary Apollonia Max

(a) Residence, No. Villa Beau - Riverview Drive St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 27, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
59 10 16

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clover Bottom, Mo

FATHER

13. NAME Francis Max 7

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Europe 0

MOTHER

15. MAIDEN NAME Catherine Mikas

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clover Bottom, Mo

17. INFORMANT Sister Mary Ludwiga
(ADDRESS) VILLA GESU.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Villa Beau Cemetery DATE December 16, 1940

19. FUNERAL DIRECTOR Theodore Fendler
(ADDRESS) 7420 Michigan Ave.

20. FILED DEC 16 1940 J. R. Meyer, M.D., P.D.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) December 13, 1940

22. I HEREBY CERTIFY, that I attended deceased from July 15, 1940 to December 12, 1940

I last saw him alive on December 12, 1940 Death is said to have occurred on the date stated above, at 10:00 am

The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis

Date of onset 2

Other contributory causes of importance: 93C

Name of operation None Date of _____

What test confirmed diagnosis? Colem Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Albert A. Wank M. D.

(Address) 8357 N. Main St. St. Louis

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....*Oliver E. J. ...*.....

Licensed Embalmer No. *4148*

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.)