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11-10-39  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **4888**

**ED MAR 25 1941**  
Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **1136**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
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1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: Jewish Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME Margaret Stone  
8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Jos. Leslie Stone 6. (c) Age of husband or wife if alive 40 yrs

7. Birth date of deceased 9/3/1902  
(Month) (Day) (Year)

8. AGE: Years 38 Months 4 Days 28 If less than one day hr. min.

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

10. Usual occupation Housewife

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

12. Name Ulrich Waltmueller

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

14. Maiden name Rose Hoffman

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

16. (a) Informant Mr. Jos. Stone

(b) Address 5853 Saloma

17. (a) Burial (b) Date thereof 2/5/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Calvary Cem.

(c) Place: burial or cremation Sullivan Und. Co.

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 2849 N. Euclid Ave.

19. (a) FEB 3 1941 (b) J. J. Bredek  
(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 limit, write "RURAL")  
(d) Street No. 5853 Saloma  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 31  
year 1941 hour 10 minute 50 P. M.  
21. I hereby certify that I attended the deceased from Nov 1  
1940, to Jan 31, 1941;  
that I last saw h. C.A. alive on Jan 31, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Utter Intestinal Obstruction  
Due to part of Adhesion and torsion of the ileum  
Due to part of 11/19/41 - Bystricture of terminal ileum - appendectomy  
Other conditions part of 1/31/41 - liver distention  
(Include prognosis within 3 months of death)  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings: Adhesions and torsion of ileum  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 D  
23. Signature J. J. Bredek (M. D. or other) \_\_\_\_\_  
Address 3120 Washington Date signed 2/1/41

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

*Albert Mayfield*

Licensed Embalmer No.

*3077*

P. O. Address

*Louis M.*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4588  
Registrar's No. 1126-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. ....

Primary Registration District No. ....

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jewish Hosp.  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Margaret Stone

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 38 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 5-2-41 (b) J. F. Predeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31 - 41  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Ac. Int. Obst. - P. D.

Adhesion - torsion ileum

Apr. 1-10-41 - Hysterectomy -

leboral hernia, Appendectomy

Other conditions Apr. 1-31-41 - for Obst.

(Include pregnancy within 3 months of death)

hysterectomy performed

Major findings: for fibroid

uterus from malignant

Of autopsy \_\_\_\_\_

Duration

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

