

No. 2
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FILED JUN 25 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16221**
Registrar's No. **3739**

Registration District No. **791** Primary Registration District No. **1003**

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 **City Hospital #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Agnes Russell**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Fred Russell** 6. (c) Age of husband or wife if alive **3** years
7. Birth date of deceased **December 3 1916**
(Month) (Day) (Year)

8. AGE: Years **24** Months **4** Days **27** If less than one day **hr. min.**

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

10. Usual occupation **At Home**

11. Industry or business

MOTHER FATHER
12. Name **Willy Stuckenbrock**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Grieshaber**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)
16. (a) Informant **Muselma Inert**
(b) Address **6702 Minnesota ave.**

17. (a) **Burial** (b) Date thereof **May 5, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New St. Peter & Paul**

18. (a) Signature of funeral director **C. Hoffmeister H & Z. Co.**
(b) Address **7814 S. Broadway**

19. (a) **MAY 1 1941** (b) **J. J. Brudek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **117**
(d) Street No. **6702 Minnesota ave.** (If rural, give location) **9**
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **30** year **1941** hour **5** minute **10p.** M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **1st 2nd 3rd Cause of backburning and legs and face with burn from gasoline which was being used to clean the engine of exploded boiler caused by a burning oil heater at her home 6752 Minnesota Ave. March 20 1941 at about 10:55 AM**

Other conditions (Include pregnancy within 3 months of death) **10:55 AM**
Major findings: Of operations **18**
Of autopsy **15**

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) **Accident**
(b) Date of occurrence **May 20 1941**
(c) Where did injury occur? **at home** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**
While at work **no** (Specify type of place) (e) Means of injury **Burn**
23. Signature **Wm. J. Gherney** (M. D. or other) **9**
Address **1214 S. 1st St.** Date signed **5/24/41**

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 Laura C. Hoffmeier
Licensed Embalmer No. 3871
P. O. Address 7814 S. Broadway

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, fact should be so stated above.