

D. 2
4-41
7-39
X25390

FILED AUG 28 1941

Registration District No. **791**

Primary Registration District No. **1003**

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:
Firmin Desloge Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **21 days**
In this community **40 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Sophia C. Vordtriede**

3. (b) If veteran, name war **---** 3. (c) Social Security No. **497-05-3607**

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

6. (b) Name of husband or wife **William** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **June 12, 1887**
(Month) (Day) (Year)

8. AGE: Years **54** Months **0** Days **24** If less than one day hr. min.

9. Birthplace **Red Bud Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Sales Lady**

11. Industry or business **Kleins Clothing Store**

12. Name **Gottlieb Koester**

13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Caroline Levine**

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

16. (a) Informant **William Vordtriede**
(b) Address **6444 Wanda Ave.**

17. (a) **Burial** (b) Date thereof **7/8/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Wacker-Teelderle**
(b) Address **3634 Gravois Ave.**

19. (a) **1961 2 INC** (b) **J. F. Breakey**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **6444 Wanda Ave.** **21**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **5**, year **1941** hour **5** minute **15** a.m.

21. I hereby certify that I attended the deceased from **6/13/41** to **7/5/41** that I last saw him alive on **7/5/41** and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Cardiovascular disease - decompensation**

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

Major findings: 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 _____
23. Signature **R. Ameyers** (M. D. or other) **0**
Address **13250 S. Grand** Date signed **7/5/41**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

JUL 7 1941

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 Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Arkansas

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.