

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **5167**

Registration District No. **318**

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: **Christian Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Franklin**

(c) City or town **Pacific**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Kathleen Hiedenfelder**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **3**
year **1943** hour **12 noon** minute _____ M.

21. I hereby certify that I attended the deceased from **at 9 am - June 3**, 19**43**, to _____, 19____;
that I last saw her alive on **June 3 - 1943**, 19____;
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May - 5 1943**
(Month) (Day) (Year)

Immediate cause of death **Pneumonia - Bronchial** Duration 1 day

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **107**

8. AGE: Years _____ Months **29** Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Pacific** **Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name **Kath. Hiedenfelder**

13. Birthplace **Pacific** **Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Erighart**

15. Birthplace **Emporia** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Kath. Hiedenfelder**

(b) Address **Pacific Mo**

17. (a) Burial **Pacific** (b) Date thereof **6-5-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pacific Mo**

18. (a) Signature of funeral director **J. F. Brucke**

(b) Address **Pacific - Mo**

19. (a) **JUN 4 1943** (b) **J. F. Brucke**
(Date received local registrar) (Registrar's signature)

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. B. Blay** (M. D. or other) _____
Address **607 n. Grand Blvd.** Date signed **6/4/43**

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 Joe L. Huber
Licensed Embalmer No. 3008
P. O. Address Pacific Mo

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.