No. 2
-1-4-41
-17-39
X2639

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19721

FILED JUN 30 1943

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 5576

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

1. PLACE OF DEATH:

(a) County
(b) City or town Saint Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saint Louis Maternity Hospital
(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: 999

(a) State Illinois (b) County Jersey 11
(c) City or town Jerseyville 0 N.R.
(If outside city or town limits, write "RURAL")
(d) Street No. Route #1
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME AGNES IRENE ISRINGHAUSEN

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

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Floyd G. Isringhausen
6. (c) Age of husband or wife if alive 21 years
7. Birth date of deceased November (Month) 15 (Day) 1923 (Year)

8. AGE: Years 19 Months 7 Days 2 If less than one day hr. min.

9. Birthplace Fieldon Illinois (City, town, or county) 1 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Leslie Schaaf
13. Birthplace Fieldon Ill (City, town, or county) 1 (State or foreign country)
MOTHER
14. Maiden name Ruth Levi
15. Birthplace Fieldon Ill (City, town, or county) 1 (State or foreign country)
16. (a) Informant St. Louis Maternity Hosp
(b) Address 630 So Kingshighway Blvd
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/18/43 (Month) (Day) (Year)
(c) Place: burial or cremation Jerseyville, Illinois
18. (a) Signature of funeral director Albert H. Hoppe, Inc
(b) Address 4700 Washington Blvd.,
19. (a) JUN 1 (Date received local registrar) 1943 (b) J. F. Bredeck (Registrar's signature)
944

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1943 hour 6 minute 15P. M.

21. I hereby certify that I attended the deceased from June 17 5:00am 1943 to 6/17/43 6:15P 19 ; that I last saw her alive on June 17, 1943 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Eclampsia	20 hrs.
Post Partum Shock	1 hr.
Due to —	
Due to —	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations None.
Of autopsy None.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. W. Vieary (M. D. or other) M.D.
Address 630 S. Kingshighway Date signed 6/17/43.

(Licensed Embalmer's Statement on Reverse Side)

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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.