

S. No. 2  
OM-2-45  
5-17-43  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

23443  
State File No. \_\_\_\_\_  
Registrar's No. 6713

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

FILED JUL 31 1943 318  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4849 Austria Ave., /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community Life. \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4849 Austria Ave.,  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 23rd  
year 1943 hour One minute 40 A. M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, Divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 16th, 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 1943 to July 23 1943  
that I last saw him alive on 7-23 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
68 0 7 hr. \_\_\_\_\_ min.

Immediate cause of death  
Ac. Cardiac dilatation  
Due to Chronic myocarditis 3 yrs  
Chronic nephritis 3 yrs

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

Other conditions mild diabetes mellitus  
(Include pregnancy within 3 months of death) Yes

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 Carl Scheining  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Not known  
15. Birthplace Not known  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mamie Sucher  
(b) Address 4106 Schiller Pl.

While at work \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_

17. (a) Burial (b) Date thereof 7/26/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sunset Burial Pk.

18. (a) Signature of funeral director John S. Ziegenhain  
(b) Address 7027 Gravois Ave.

23. Signature Louis S. Recollet (M. D. or other)  
Address 742 Lemay Ferry Rd Date signed 7/24/43

19. (a) JUL 23 1943  
(Date received for local registration) (Registrar's signature)

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**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..... *C. P. Kidwell* .....

Licensed Embalmer No. *3877* .....

P. O. Address *7027 Brouais* .....

**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.**