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X3597

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

FILED OCT 9 1943

Registration District No. **1943**

Primary Registration District No. **3069**

Registrar's No. **2230**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME **Barth Staehlin**

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

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

6. (b) Name of husband or wife **Orble Staehlin** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **January 17, 1896**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	47	8	13	hr. _____ min.

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

10. Usual occupation **Elevator Inspector**

11. Industry or business **City of St. Louis**

MOTHER FATHER

{ 12. Name **Henry Staehlin**

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

{ 14. Maiden name **Marie Lederer**

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

16. (a) Informant **Lee Staehlin**

(b) Address **2020 Ann Ave.**

17. (a) **Burial** (b) Date thereof **Oct. 2, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Picker's Cemetery**

18. (a) Signature of funeral director **Weick Bros.**

(b) Address **Grand Bl.**

19. (a) **OCT 4 1943** (b) *[Signature]*
(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") **9**
(d) Street No. **2020 Ann Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **30**
year **1943** hour **3** minute **10** A.M.

21. I hereby certify that I attended the deceased from **Sept 29 1943** to **Sept 30 1943**
that I last saw him alive on **Sept 29** and that death occurred on the date and hour stated above.

Immediate cause of death **acute glomerular nephritis**

Due to _____
Due to _____
Other conditions **uremia**
(Include pregnancy within 3 months of death) **5 days**

Major findings:
Of operations _____
Of autopsy _____

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature *[Signature]* (M.D. or other)
Address **3115 S Grand** Date signed **9/30/43**

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 *Wm. A. Stewart*

Licensed Embalmer No..... **3722**.....

P. O. Address..... **412 Duchouquette St.**.....

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.

Oct -
2230

Registration District No. 317

Primary Registration District No. 3069

Registrar's No.

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Mary's Heights
(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)

3. (a) PRINT FULL NAME Bath Staehlin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:

Years 47 Months 8 Days _____ If less than one day _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration glomerular nephritis
Due to _____
Due to _____
Other conditions Wernia
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: N.M.O.
Of operations _____
Of autopsy _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

32653

NOV 19 1943