

FILED OCT 22 1943 818

1003

9092

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

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

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis, Mo  
(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 Alexander Brothers O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community From 9/15 to 10/11/43 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis  
(c) City or town Washington  
(If outside city or town limits, write "RURAL")  
(d) Street No. Kennedy Rd.  
(If rural, give location) N.R.  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HENRY W. STAHL

3. (b) If veteran, name war No  
3. (c) Social Security No. 495-03-3398

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

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

7. Birth date of deceased Oct 27 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 11 14 hr. min.

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

10. Usual occupation Brewery Worker

11. Industry or business Brewery

12. Name Jacob Stahl

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name not known

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Wife Mrs State Stahl

(b) Address Washington - m

17. (a) Burial (b) Date thereof Oct. 14, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Ziegenhein Bro.

(b) Address 2408 Grayoia Ave.

19. (a) OCT 15 1943 (b) J. F. Budeak  
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 1943  
year 1943 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from 11/4/42  
1942 to 10/11/43 1943

that I last saw him alive on 10/11/43  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral and Cardiac Infarct Duration 4 Weeks

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions External scleritis 10 Years  
(Include pregnancy within 3 months of death)

Major findings: Infarct of Brain that  
Of organs Frang. Kidney  
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 0

23. Signature William Dmta (M. D. or other)

Address 3450 Truman Date signed 10/12/43

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

MOTHER FATHER

**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 N. E. Harris

Licensed Embalmer No. 3360

P. O. Address.....

**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.**