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23425
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 1 1944

THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5645

State File No.

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1739**

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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 5 days
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... Missouri (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No..... 5325 Easton Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... ESTHER RICHTER
(b) If veteran, name war..... None
(c) Social Security No..... None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... Feb. day..... 19th
year..... 1944 hour..... 11:40 minute..... P. M.

4. Sex..... Female 5. Color or race..... White
6. (a) Single, widowed, married, divorced..... Married
6. (b) Name of husband or wife..... Emil Richter
6. (c) Age of husband or wife if alive..... 54 years
7. Birth date of deceased..... Sept. 5 1895
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from..... Feb. 14th
..... 1944 to..... Feb. 19th, 19 44
that I last saw h. ER alive on..... Feb. 19th, 19 44
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
58 5 14 hr. min.

Immediate cause of death.....
Regional Ileitis & Rheumatic Heart Disease
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

9. Birthplace..... St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation..... Housewife

Major findings:
Of operations.....
Of autopsy..... Regional Ileitis & Rheumatic Heart Disease (Mitral Stenosis)
PHYSICIAN.....
Underline the cause to which death should be ascribed

11. Industry or business.....
12. Name..... William Whitney
13. Birthplace..... Baltimore Maryland
(City, town, or county) (State or foreign country)
14. Maiden name..... Minnie Green
15. Birthplace..... Unknown England
(City, town, or county) (State or foreign country)

16. (a) Informant..... Minnie Edwards
(b) Address..... 5808 Theodosia
17. (a) Burial (b) Date thereof..... 2-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... Memorial Park Cemetery

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).....

18. (a) Signature of funeral director..... Albert H. Hoppe
(b) Address..... 4700 Washington Blvd.
19. (a) FEB 22 1944 (b) J. Thedeck
(Date received local registrar) (Registrar's signature)

While at work?..... (e) Means of injury.....
23. Signature..... J. L. Campbell (If S. or other)
Address..... 1515 Lafayette Date signed..... 2/21/44

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

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.....

Albert G. Happe

Licensed Embalmer No.....

2971

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1739

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____
7. Birth date of deceased Sept. 5, 1895
(Month) (Day) (Year)

8. AGE: Years (48) Months 5 Days 14 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) 3-17-44 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(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 Feb. day 19th
year 1944 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

5645