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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAR 27 1944 318

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

Registrar's No. 2641

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:  
4259 Connecticut St.  
(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  
(If outside city or town limits, write "RURAL")

(d) Street No. 4259 Connecticut St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Agnes Troeber

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

4. Sex Female 5. Color of race White 6. (g) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased March 8, 1877  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 18  
year 1944 hour 745 minute P.M. M.

21. I hereby certify that I attended the deceased from March 18, 1944 to March 18, 1944  
that I last saw her alive on March 18, 1944  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<u>67</u>	<u>0</u>	<u>0</u>	<u>10</u>	hr. _____ min. _____

Immediate cause of death Coronary Thrombosis Duration 2 days

Due to Acute Proximalis 2 weeks

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

Other conditions 9/4  
(Include pregnancy within 3 months of death)

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

10. Usual occupation At Home

11. Industry or business At Home

12. Name George Wessels

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

14. Maiden name Mary Kroeger

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Elizabeth Wessels

(b) Address 4259 Connecticut st.

17. (a) Burial (b) Date thereof 3-21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S.S. Peter & Paul Cem.

18. (a) Signature of funeral director W. S. Peter & Paul Cem.  
(b) Address 3809 S. Grand Blvd.

19. (a) MAR 20 1944 (b) J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

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 Walter P. Eigelman (M. D. or \_\_\_\_\_)  
Address 3146 Morganford Date signed 3-20-44

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 *John Agonowski*  
Licensed Embalmer No. *3398*  
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.**