

FILED MAY 15 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13198
State File No. 4266
Registrar's No.

Registration District No.

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3636 Shaw
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 066
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3636 Shaw
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Olivia Frances Peirick

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased March 4 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 2 1 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Herman Peirick

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

14. Maiden name Magdalena Bauer

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

16. (a) Informant Seraphina Lenau

(b) Address 3668 Shaw

17. (a) Burial (b) Date thereof 5-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moselle, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 8, 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year 1944 hour 6:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 17
May 5 1944 to _____ 1944;
that I last saw her alive on May 5 1944;
and that death occurred on the date and hour stated above
Immediate cause of death Angina pectoris Duration _____

Due to _____

Due to GH

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 [Signature] M.D. or other _____
Address 3284 Franklin Date signed 5/8/44

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

Robert E. Hoppe

Licensed Embalmer No..... *29711*

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.