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5-17-39
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29623

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **8076**

FILED OCT 9 1944
318
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:
Deo Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Mad**
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **6757 Etzel Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Otto J Mertens**

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, **Widower**

6. (b) Name of husband or wife **Mayme Mertens** 6. (c) Age of husband or wife if alive **Dead** years

7. Birth date of deceased **July 24** Th **1887** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 ----- **1** --- **27-0** hr. min.

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

10. Usual occupation **Taxie (Owner)**

11. Industry or business _____

12. Name **Theodore Mertens**

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

14. Maiden name **Not known**

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

16. (a) Informant **Theodore J Mertens**

(b) Address **6735 Etzel Ave** **1944**

17. (a) **Burial** (burial, cremation, or removal) (b) Date thereof **Sep. 23 D** (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Edward Koch**

(b) Address **3516 N 14 Th Str**

19. (a) **SEP 21 1944** (Date received local registrar) (b) **J. Thoresen** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **20** year **1944** hour **9** minute **10** M.

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

Immediate cause of death **Myocardial Infarction**
Coronary artery disease
When the car which he was driving collided with a front loader post in front of the City public health office at Broadway and O'Fallon about 12:30 AM 9/17/44

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations **1/10**
Of autopsy **1/10**

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **Sept 17 1944**

(c) Where did injury occur? **St Louis** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Public place**
While at work? **W** (Specify type of place) **see above**

23. Signature **W. Perry** (M, D, or other) _____
Address **Clippings Branch** Date signed **9/21/44**

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

MOTHER FATHER

2644

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

Howard P. Rowland

Licensed Embalmer No.

3114

P. O. Address

St Louis Mo

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.