

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. _____

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:
8229 Idaho
(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 Mo. (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 8229 Idaho
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Peter A. Stahl
 3. (b) If veteran, name war No. _____
 3. (c) Social Security No. 488-07-2107

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 10
 year 1944 hour 4.40 minute _____ P. _____ M. _____

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Ernestine
 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased February 18 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9/11 1944 to 10/10 1944
 that I last saw him alive on 10/10/44 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>7</u>	<u>22</u>	hr. _____ min. _____

Immediate cause of death chronic degenerative nephritis
chronic coronary arteries
myocarditis
 Duration _____

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

Due to _____
 Due to 131
 Other conditions General Anasarca
(Include pregnancy within 3 months of death)

10. Usual occupation Greenhouse work
 11. Industry or business City of St. Louis

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER, FATHER {
 12. Name Jacob Stahl
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Rabbi
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ernestine Stahl
 (b) Address 8229 Idaho Ave.
 17. (a) Burial (b) Date thereof 10/14/44
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Mt. Hope
 18. (a) Signature of funeral director Jas. P. Fandl Jr.
 (b) Address 7128 Michigan Ave
 19. (a) OCT 11 (b) J. F. Breda
(Date received local registrar) (Registrar's signature)

While at work? _____
(Specify type of place)
 (e) Means of injury _____
 23. Signature EW [Signature] (M. D. or other) _____
 Address 1504 St. Grand Date signed 10/11/44

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

STATEMENT BY LICENSED EMBALMER

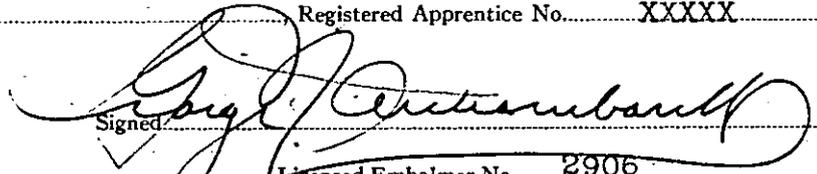
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

George N. Archambault

Registered Apprentice No. XXXXX

working under my personal supervision.

Signed.....



Licensed Embalmer No. 2906

P. O. Address 7128 Michigan Ave.

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.