

S. No. 2
M-8-43
2-5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 30 1944
318
Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

35796
State File No.
9881
Registrar's No.

Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1900 A Wyoming
(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 Ida A. Dielschneider
3. (b) If veteran, name war _____
3. (c) Social Security No. None

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

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years approx 89 Months _____ Days _____
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Oscar E. Buder

(b) Address 7th & Market- Buder Bldg.

17. (a) Burial (b) Date thereof 11/22/44
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Wm. J. Robert L. & U. Co.

(b) Address 1905 S. Grand Blvd.

19. (a) NOV 21 1944 (b) J. A. Buder
(Date received local registrar) (Registrar's signature)

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. 1900 A Wyoming
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 1944 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from Jan. 5
1944 to Nov 20 1944
that I last saw her alive on Nov 20 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
ac. Cardiac failure

Due to Chr. myocarditis
Senility

Due to _____
Other conditions Trac. Hif about 1 yr ago
(Include pregnancy within 3 months of death) (Healed)

Major findings:
Of operations _____
Of autopsy _____

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)
While at work? _____ (e) Means of injury _____

23. Signature Leo P. Young (M. D. or other) _____
Address 2621 S. Jefferson Date signed 11/22/44

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

Hawaii A. Powell

Licensed Embalmer No. *314*

P. O. Address *21 Lewis M*

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.