

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

W. McLean 2082
State File No. _____
Registrar's No. 2570

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 12 1945

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2570

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

1. PLACE OF DEATH:
(a) County St. Louis,
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Shoede Rd. near Olive St. Rd. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community 66 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis, 96
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Shoede Rd. near Olive St. Rd.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME Margretha E. Fink,
3. (b) If veteran, name war none
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 25,
year 1944 hour 7 minute 30 A. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife David Fink,
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Mar. 19, 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-20 to 12-25 1944
that I last saw her alive on 12-25 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 9 Days 6
If less than one day hr. _____ min. _____

Immediate cause of death Coronary occlusion
Due to Chr. Myocarditis
Due to Hypertension

9. Birthplace St. Louis Co. Mo. 19
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 938
Of autopsy _____
Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife

11. Industry or business Own home,

12. Name Gottfried Stein, 11

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

14. Maiden name Charlotte Langewisch,

15. Birthplace St. Louis, Mo. 1931
(City, town, or county) (State or foreign country)

16. (a) Informant David Fink,

(b) Address Creve Coeur, Mo. R. #2.

17. (a) Burial (b) Date thereof DEC-28-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Elm Lawn Cem.

18. (a) Signature of funeral director Schrader Funeral Home

(b) Address Ballwin, Mo.

19. (a) DEC 28 1944 (b) E. H. McLauran
(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? _____
(Specify type of place) (e) Means of injury Car
Signature Royal C. McLean M.D. (M. D. or other) _____
Address 12-26-44 Date signed _____

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.....

Theo. Schrader

Licensed Embalmer No.....

3066

P. O. Address.....

Balwin, 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.