

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

3879

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 13 1945

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 2887

1. PLACE OF DEATH: **St. Louis County**

(a) County **St. Louis County**

(b) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Mary's Hospital**
(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 0

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **Ferguson**
(If outside city or town limits, write "RURAL") 16

(d) Street No. **423 Nancy**
(If rural, give location) 2

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Albina Fleischmann**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased **February 28 1879**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

65	10	24	_____ hr. _____ min.
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9. Birthplace **Austria**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Aerts**

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

14. Maiden name **"**

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

16. (a) Informant **Albina Kern**

(b) Address **4857 Anderson Ave.**

17. (a) **Burial** (b) Date thereof **1/25/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Stroot-Carroll**

(b) Address **4600 Natural Bridge Ave.**

19. (a) **JAN 26 1945** (b) **E. J. McLaughan**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **22,** year **1945** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **JAN 22** 19 **45** to **JAN 22** 19 **45**

that I last saw her or alive on **Jan 22** 19 **45** and that death occurred on the date and hour stated above.

Immediate cause of death **General carcinoma of right breast**

Due to _____

Due to _____

Duration

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations **50**

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 place) (Means of injury)

Signature **[Signature]** (M. D. or other) _____

Address **3100 Grand Blvd** Date signed **1/23/45**

(Licensed Embalmer's Statement on Reverse Side)

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

76
2-5-0. 2-3-8

SEP 18 1945

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..... *Alfred J. Boedeker*
Licensed Embalmer No. *2663*
P. O. Address *5934 alpha*

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.