

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 2967

1. PLACE OF DEATH:
 (a) County St Louis
 (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 1 hour
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 5886 Enright 9
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Anthony Philipp Stolze

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased November 20 1944
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	---	2	13	hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER {
 12. Name Joseph Stolzeder
 13. Birthplace Alton Ill
(City, town, or county) (State or foreign country)

{
 14. Maiden name Bertha Schneider
 15. Birthplace St Charles Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Packer - Joseph J. STOLZE
(b) Address 5886 ENRIGHT

17. (a) Burial (b) Date thereof Feb 6 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Western Lutheran

18. (a) Signature of funeral director Beiderwieden F H Inc

(b) Address 1936 St Louis Ave

19. (a) FEB 6 1945 (b) E. S. McLaurs
(Date received local health) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1945 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan 30, 1945, to Feb 3, 1945, that I last saw him alive on Feb 3, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death
Secondary broncho-pneumonia 2 days
 Due to Congenital heart disease
Ventricular septal defect -
Down's Deformity of aorta
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations 1572
 Of autopsy Cardiac malformation
Broncho-pneumonia
 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 type of place)
 (e) Means of injury S
 Signature T. S. Schryber (M. D. or other) M.D.
 Address 536 N. Taylor Date signed 2/5/45

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

Dr Zalusky, JR 6033
536 N Taylor Ave

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

Glen W. Hart

Licensed Embalmer No.

3737

P. O. Address

1936 St. Louis 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.