

S. No. 2  
M-5-43  
7. 5-17-39  
X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4695**  
Registrar's No. **2023**

**MAR 14 1945**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis City Hospital #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days  
(Specify whether years, months or days)

In this community 40 yrs

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3760 Marine  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mike Pfeiffer

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

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 6th. ?  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28th  
year 1945 hour 12:30 minute P. M.

21. I hereby certify that I attended the deceased from 2/20/45  
\_\_\_\_\_, 19\_\_\_\_, to 2/28/45, 19\_\_\_\_;  
that I last saw him alive on 2/28/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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

abt 63 - - - hr. min.

Immediate cause of death Coronary Occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 94 a

9. Birthplace Hungary (City, town, or county) (State or foreign country) H

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

12. Name Mike Pfeiffer

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

14. Maiden name Anna ?

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

Major findings:

Of operations \_\_\_\_\_

Of autopsy Same

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Lucy Lorenz

(b) Address 3760 Marine

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 2 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Macker-Hilderich & Sons

(b) Address 3634 Sparrows Ave

19. (a) MAR 2 1945 (Date received local registrar) (b) J. J. Bedeck (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature James J. South (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Date signed 2/28/45

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.....

*No Embalming*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Frank J. [unclear]*

Licensed Embalmer No. *9475*

P. O. Address: *St. Louis*

**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.**