

S. No. 2
M-8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 16 1945

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

State File No. **7954**
Registrar's No. **2201**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3504 University street
(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 Caroline Lietz
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Charles F. Lietz
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 28 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 10 8 hr. _____ min.

9. Birthplace Johnnesburg Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation at home
11. Industry or business at home

MOTHER FATHER
12. Name Herman Kasting
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Schisler
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Harold Lietz
(b) Address 5938 Goodfellow

17. (a) burial (b) Date thereof March-9 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery
18. (a) Signature of funeral director A. Row Leu Co.
(b) Address 2707 No. Grand Bly'd

19. (a) MAR 7 1945 (b) J. Gredek
(Date received local registrar) (Registrar's signature)

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. 3504 University st
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6 year 1945 hour 8 minute 40 A.M.

21. I hereby certify that I attended the deceased from February 12, 1945 to March 6, 1945
that I last saw her alive on March 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism Duration 22 days

Due to Chronic Rheumatic Heart Disease with Mitral Disease Indefin.

Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None
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 type of place) (e) Means of injury _____
23. Signature Edwin S. Schisler (M.D. or other) F.A.C.P.
Address 445 Missouri Bldg. Date signed 3/7/45

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

APP 210 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.....

V. E. Morris

Licensed Embalmer No.....

3360

P. O. Address.....

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.