

7997

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 6 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2587**

1. PLACE OF DEATH:

(a) County **St. Louis**

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

(c) Name of hospital or institution: **St. Anthony's Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Mo.**
(Specify whether years, months or days)

In this community **St. Louis**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **999**

(c) City or town **Chicago** **11**
(If outside city or town limits, write "RURAL")

(d) Street No. **3028 N. Parkside Ave.** **NR.**
(If rural, give location)

(e) Citizen of foreign country? **2** (Yes or No)
If yes, name country **2**

3. (a) PRINT FULL NAME **Amelia Mahlmann**

3. (b) If veteran, name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **20**
year **1945** hour **2** minute **15 P.M.**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **August**

6. (c) Age of husband or wife if alive **78** years **1860**

7. Birth date of deceased: (Month) **Feb.** (Day) **8** (Year) **1860**

21. I hereby certify that I attended the deceased from **3-21-45**
19 **45**, to **3-20-1945**
that I last saw h. **3-20-1945** alive on **3-20-1945**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	85	1	12	hr. min.

Immediate cause of death: **Ch. Myocarditis**

Due to **Senility**

Due to **50**

Other conditions: **Ca of rt. breast.**

(Include pregnancy within 3 months of death)

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

10. Usual occupation **Home**

Major findings: **Ca of rt. breast**

Of operations.....

Of autopsy.....

PHYSICIAN **—**

Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name **Lorenz Steinbrecher**

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

14. Maiden name **Christina Klos**

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

Date of occurrence.....

(b) Where did injury occur?.....
(City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) (e) Means of injury

16. (a) Informant **August Mahlmann**

(b) Address **3028 N. Parkside Ave., Chicago**

17. (a) **Burial** (b) Date thereof **Mar. 23, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Wacker Helderle**

(b) Address **3634 Gravois Ave.**

19. (a) **MAR 21 1945** **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

23. Signature **W.F. Yeager** (M. D. or other) **MD**

Address **3115 N. Grand** Date signed **3/20/45**

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

Signed Robert Wheeler
Licensed Embalmer No: 2128
P. O. Address Stamington

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.