

S. No. 2  
OM-8-13  
ev. 5-17-39  
I X37823

8283

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  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 2749

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: Lutheran Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether)

In this community 40 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 4128 A Nebraska  
(If rural, give location)

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

3. (a) PRINT FULL NAME Viola V. Stiehr

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 married

6. (b) Name of husband or wife Henry

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased May 9th. 1889  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch .25 day.  
year 1945 hour 4 minute 15 M.

21. I hereby certify that I attended the deceased from 2-22  
1945, to 3-20, 1945  
that I last saw her alive on 3-24, 1945  
and that death occurred on the date and hour stated above.

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

55 10 16 hr. min.

Immediate cause of death Inter-racial remarriage, acute stroke

Due to Diabetes mellitus

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation House Work

Major findings: W

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

12. Name Vincent Bacigalupo

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

14. Maiden name Anna Heye

15. Birthplace St. Charles Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Hy. W. Stiehr

(b) Address 4128 A. Nebraska

17. (a) burial (b) Date thereof 3-28-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope

18. (a) Signature of funeral director Mr. Schumacher  
(b) Address 3013 Meramec

19. (a) MAR 27 1945 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

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

(c) 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? \_\_\_\_\_

(Specify type of place)

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

23. Signature Wm. K. Carroll (M. D. or other) MD  
Address 4540 Olive Date signed 3/26

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

Dr. J. J. J. J.  
1500  
O. J. J. J.

*Embalmer's separate Cert to be filed*

STATEMENT BY LICENSED EMBALMER

MAR 27 1945

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.....

Licensed Embalmer No.....

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.**