S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

#37034
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8296

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2483

1. PLACE OF DEATH:

(a) County

(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. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos-20 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 9

(a) State Mo (b) County

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

(d) Street No. 5022 N Brodway
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MARGARET STUCKENSCHNEIDER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 26 Th (Day) 1880 (Year)

8. AGE: Years 64 ------- Months 11-- Days 10 - If less than one day hr. min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Bernard Wegman
13. Birthplace Germany (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Not Known
15. Birthplace Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant Christ Stukenschneider
(b) Address 819 East Prarie Ave 1945

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20 Th (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Edward Koch
(b) Address 3514 N 14 Th Str

19. (a) MAR 1 2 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

March 18-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16th year 1945 hour 4:00 minute P. M.

21. I hereby certify that I attended the deceased from 12/24/44, 19, to 3/16/45, 19; that I last saw her alive on 3/16/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Cachexia

Due to lung abcess & subdiaphragmatic abcess

Due to carcinoma of ampulla of vater with local metastasis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations as above 46

Of autopsy as above

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address City Hospital 1515 Lafayette Date signed 3/17/45

(Licensed Embalmer's Statement on Reverse Side)

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: Ronald O Yahnke

Licensed Embalmer No. 3947

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.