7. S. No. 2
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ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21317

Registration District No. 317 Primary Registration District No. 6676 Registrar's No. 1553

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robt. Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2826 days (Specify whether years, months or days)
In this community 2826 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County —
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2801 a Dodier
(If rural, give location)
(e) Citizen of foreign country? NO ? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LESTER, ADALIA
3. (b) If veteran, name war —
3. (c) Social Security No. None
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Harry O. Lester
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased July (Month) 13 (Day) 1890 (Year)
8. AGE: Years 54 Months 11 Days 0 If less than one day hr. min.
9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation House wife
11. Industry or business "
12. FATHER Name Herman Wollberg
13. FATHER Birthplace Germany (City, town, or county) (State or foreign country)
14. MOTHER Maiden name Sophie Modell
15. MOTHER Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation Sun Set Burial Park
18. (a) Signature of funeral director Provost Und. Co.
(b) Address 3710 N. Grand Bl.
19. (a) JUN 15 1945 (Date received local registrar) (b) E. C. McCarran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1945 hour 8 minute 35 A.M.
21. I hereby certify that I attended the deceased from July 13, 1938, to June 13, 1945; that I last saw her alive on June 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chr. Pulmonary Tuberculosis	25 yrs.?
Due to	
Due to 13	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Pulmonary Tuberculosis	

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 [illegible] (M. D. or other) M. D.
Address Koch Hosp. Koch, Mo. Date signed 6-13-45

(Licensed Embalmer's Statement on Reverse Side)

JUN 20 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 Earl E. Grover

Licensed Embalmer No. 157

P. O. Address 3710 N Grand

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.