

S. No. 2  
FORM-2-43  
Rev. 5-17-39  
X33597

28423

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 0  
Registrar's No. #46234

FILED AUG 18 1945

Registration District No. 317 Primary Registration District No. 6076

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

1. PLACE OF DEATH:  
(a) County ST. LOUIS  
(b) City or town Rural - Gravois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4744 Heidelberg Ave.,  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4744 Heidelberg Ave.,  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Kate De Wald  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 13th  
year 1945 hour 4 minute 45 P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Nick 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased Sept 13th, 1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 10, 1945 to Aug 11, 1945  
that I last saw him or her alive on Aug 11th, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
53 11 0 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Coronary occlusion  
Due to Droopy coronary  
Due to 94a  
Other conditions Arterio-sclerosis  
(Include pregnancy within 3 months of death)

9. Birthplace Europe  
(City, town, or county) (State or foreign country)  
10. Usual occupation At home  
11. Industry or business \_\_\_\_\_

Major findings:  
Of operations   
Of autopsy   
PHYSICIAN  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name John Becker  
13. Birthplace \_\_\_\_\_ Europe  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_ Boehmer  
15. Birthplace \_\_\_\_\_ Europe  
(City, town, or county) (State or foreign country)

16. (a) Informant Nick De Wald  
(b) Address 4744 Heidelberg Ave.  
17. (a) Burial (b) Date thereof 8/16/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lakewood Burial Park

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? \_\_\_\_\_

18. (a) Signature of funeral director John L. Ziegenhagen  
(b) Address 7027 Gravois Ave.  
19. (a) 8-16-45 (b) E. J. De Haven  
(Date received local registrar) (Registrar's signature)

While at work?  (Specify type of place) \_\_\_\_\_  
23. Signature W. C. P. Scott M. D. or other \_\_\_\_\_  
Address 4356a Manchester Date signed 8-14-45

OCT 10 1945

OCT 15 1945

OCT 2 1946

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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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 7027 Yravis

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.