

S. No. 2
OM 5-43
v. 17-9
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28526**
Registrar's No. **2099**

FILED SEP 4 1945

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County... **St. Louis**

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

(c) Name of hospital or institution:
4643 Siebert 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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... **Missouri** (b) County... **St. Louis** **96**

(c) City or town... **Afton** **n**
(If outside city or town limits, write "RURAL")

(d) Street No... **4643 Siebert Ave** **0**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Magdalena Ofzky**

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

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **24th** day **August**
year **1945** hour **5:25** minute _____ A.M.

4. Sex **Female** **5. Color or** **White** **6. (a) Single, widowed, married,** **Widow**
race _____ divorced _____

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased **January 26 1889**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug** 19 **45**, to **Aug** 24 **45**,
that I last saw her alive on **24 Aug** 19 **45**,
and that death occurred on the date and hour stated above.

Immediate cause of death **pleuritis** **Duration** _____

8. AGE:

Years	Months	Days	If less than one day
56	6	29	_____ hr. _____ min.

Due to **61**

Due to _____

9. Birthplace **Austria** **4**
(City, town, or county) (State or foreign country)

Other conditions **Myocarditis Chrono**
(Include pregnancy within 3 months of death)

10. Usual occupation **At Home**

11. Industry or business _____

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

12. Name **Frederick Gall**

13. Birthplace **Austria** **4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Austria** **4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Anna Baker**

(b) Address **4643 Siebert Ave**

17. (a) Burial (b) Date thereof **Aug 27 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Ziegenbein Bros**

(b) Address **6409 Graydon Ave**

19. (a) 8-28-45 (b) **E. H. McBurney**
(Date received local registrar) (Registrar's signature)

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

Signature **Emil G. Burs** (M. D. or other) _____

Address **1901 Cherokee** Date signed **8-26-45**

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

MOTHER FATHER

*No. Burt
1900 Charles St.
La-0120*

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. *3917*

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.