

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State, File No. **29420**
Registrar's No. **8294**

FILED OCT 6 1945
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
5711 South Grand Blvd. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 30 years
(Specify whether years, months or days)

In this community 30 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 5711 South Grand Blvd.
(If rural, give location)

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

3. (a) PRINT FULL NAME Dr. Willis N. Stuver

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Gertrude Brandau Stuver 6. (c) Age of husband or wife if 56 years

7. Birth date of deceased October 21, 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	11	2	hr. _____ min. _____

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

10. Usual occupation Osteopath

11. Industry or business Physician

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gertrude Brandau Stuver

(b) Address 5711 So. Grand Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/45
(Month) (Day) (Year)

(c) Place: burial or cremation Brookfield, Missouri

18. (a) Signature of funeral director Beiderwieden F. H., Inc

(b) Address 1926 1945 Louis Avenue,

19. (a) SEP 26 1945 (Date received local registrar) (b) J. F. Predeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23,
year 1945 hour 6: minute 15 A. M.

21. I hereby certify that I attended the deceased from Nov 1939
to Sept. 23, 1945
that I last saw him alive on Sept 22, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction
Due to arteriosclerosis years
Due to Chronic myocarditis years

Other conditions 93d
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 9

23. Signature Thomas C. Edwards M. D. or other Dr
Address 3115 S. Grand Date signed 9/23/45

Duration 1 week

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No..... 3797

P. O. Address..... 1936 St. Louis Ave

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.