7. S. No. 2
00M—5-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31490

FILED OCT 6 1945

Registration District No. 3177 Primary Registration District No. 3068 Registrar's No. 2210

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Maplewood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Maplewood Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 000
(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No.: 5404 Dewey 9
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) 1
If yes, name country ____

3. (a) PRINT FULL NAME: Augusta Mundwiller
3. (b) If veteran, name war: No.
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Alvin
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Jan. (Month) 7 (Day) 1863 (Year)

8. AGE: Years	Months	Days	If less than one day
82	8	23	____ hr. ____ min.

9. Birthplace: Hermann (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____
FATHER 12. Name: John Kirchner
13. Birthplace: ____ (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name: Mary Vogel
15. Birthplace: ____ (City, town, or county) Switzerland (State or foreign country)
16. (a) Informant: A. E. Mundwiller
(b) Address: 2027 Princeton Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Hermann, Mo.
18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.
19. (a) 10-2-45 (Date received local registrar) (b) E. S. McGowan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30 year 1945 hour 5:20 minute P. M.
21. I hereby certify that I attended the deceased from 6-5, 1945, to 9-29, 1945, that I last saw her alive on 9-29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bowel obstruction	4 days
Due to: Hypertrophy of liver	
Due to: Senility 125 a	
Other conditions: Arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

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: J. A. Sterling (M. D.)
Address: Maplewood Date signed 10-1-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Sterling

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 Elmo K. Sadwell

Licensed Embalmer No. 4077

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.