

#46109  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

32160  
State File No. 9328  
Registrar's No.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days  
(Specify whether \_\_\_\_\_)

In this community 80 years  
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. 1830 So. 9th St.,  
(If rural, give location)

(e) Citizen of foreign country? ? (Yes or No) ?

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HUGO MALKE

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

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: April 26th, ??  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2nd  
year 1945 hour 11:15 minute P. M.

21. I hereby certify that I attended the deceased from 9/14/45  
19\_\_\_\_ to 10/2/45, 19\_\_\_\_;

that I last saw him alive on 10/2/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above

8. AGE: Years abt 81 Months - Days -  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death myocardial failure Duration \_\_\_\_\_

Due to Arteriosclerotic Heart Disease

Due to \_\_\_\_\_

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

10. Usual occupation Nil

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

11. Industry or business \_\_\_\_\_

12. Name Unk.

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

14. Maiden name Colleen Unk

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical Board Date thereof 10-9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director J. F. Bredek

(b) Address \_\_\_\_\_

19. (a) OCT 29 1945 Date received local registrar  
J. F. Bredek 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? \_\_\_\_\_

23. Signature W. J. Hamilton (M. D. or other) MD  
Address 1515 Lafayette Date signed 10/3/45

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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.....

Licensed Embalmer No.....

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.**