

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

32262

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 9521

FILED NOV 31 1945
Registration District No. _____

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one month
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 4719 Allemania
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Lillian A Pfeiffer

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Frank Pfeiffer

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased April 6, 1877
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1945 hour 12 minute 55 A.M.

21. I hereby certify that I attended the deceased from July 30
30, 19 45 to Oct. 30, 19 45;

that I last saw h. or alive on October 29, 19 45
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>6</u>	<u>24</u>	_____ hr. _____ min.

Immediate cause of death General Carcinomatosis

Due to Cancer of Uterus (Inoperable) and appendages Since March

Due to General Arteriosclerosis

9. Birthplace St Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Carl Gerak

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

14. Maiden name Foster

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

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

Major findings:
Of operations None

Of autopsy None

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant Frank Pfeiffer

(b) Address 4719 Allemania

17. (a) burial (b) Date thereof 11/2/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St marcus cem

18. (a) Signature of funeral director J. I. Ziegenhein & Sons

(b) Address 7027 Gravois

19. (a) NOV 3 1945 (Date received local registrar)

J. F. Bredesk (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)

Means of injury _____

23. Signature Edwin J. Schisler, M.D., F.A.C.P. (M. D. or other)

Address 945 Missouri Bldg. Date signed 10/31/45

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 Graves*

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.