

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 39269
Registrar's No. 11249

FILED JAN 18 1946
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
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Lutheran-Altenheim
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Magdalena Kiefer

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

4. Sex Female / 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: July 26 1858
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>87</u>	<u>4</u>	<u>24</u>	hr. _____ min. _____

9. Birthplace Red Bud Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

MOTHER FATHER

11. Industry or business _____

12. Name Anton Kiefer

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

14. Maiden name Magdalena

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

16. (a) Informant M. E. Lorenz
(b) Address 8721 Halls Ferry Road

17. (a) Burial (b) Date thereof Dec. 22, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Beiderwieden Funeral Home
(b) Address 1936 St. Louis Ave

19. (a) DEC 20 1945 (b) J. F. Budnik
(Date of registration) (Registrar's signature)

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. 8721 Halls Ferry Road
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 20, year 1945, hour 9, minute 30 A.M.

21. I hereby certify that I attended the deceased from July 10 1945 to Dec 20 1945
that I last saw her alive on Dec 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: chronic myocarditis Duration 2 yrs?

Due to _____

Due to _____

Other conditions: arteriosclerosis Duration 10 yrs?
(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? _____

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

23. Signature Eugene P. Arnold (M. D. or other) M.D.
Address 1449 Mc Laran Date signed 12/21/45

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.....
Allen W. Hat

Licensed Embalmer No.....
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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.