S. No. 2
OM—2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 27 1946

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 10771

Registration District No. 317 Primary Registration District No. 6676 Registrar's No. 634

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

**1. PLACE OF DEATH:**

(a) County St. Louis
(b) City or town Lemay, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: #6 Rosebank Dr.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____ years, months or days)

**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. 4404 Osceola St. 9
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Theresa Knapp
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 Widow
6. (b) Name of husband or wife William
6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased Feb. (Month) 22 (Day) 1883 (Year)

8. AGE: Years 63 Months 0 Days 22 If less than one day ____ hr. ____ min.

9. Birthplace St. Genevieve (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Home
11. Industry or business ____

FATHER
12. Name Joseph Stumpf
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant Lucille Zaitz
(b) Address #6 Rosebank Dr. Lemay, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (Month) (Day) (Year)
(c) Place: burial or cremation St. Trinity Luthern Cem.
18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Ave.
19. (a) 3-16-46 (Date received local registrar) (b) E G McGanan M D (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar. day 14 year 1946 hour 12 minute 10 A M.
21. I hereby certify that I attended the deceased from Sept 1, 1944, to Mar 14, 1946; that I last saw her alive on Mar 14, 1946; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Hypostatic Pneumonia | 4 day |
| Due to Carcinoma of rt breast c̄ | |
| Due to Metastasis to Lungs | 3 yrs |
| Other conditions (Include pregnancy within 3 months of death) 50 | |

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 H Phelan M D (M. D. or other) M D
Address 3608 S Grand Date signed 3-15-46

707 (Licensed Embalmer's Statement on Reverse Side)

## 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. 2645

P. O. Address. St Louis Mo

**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.**