#54503

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 20 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11429

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2346

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 0 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 17 (200)

(c) City or town St. Louis 223
(If outside city or town limits, write "RURAL")

(d) Street No. 1419 S. 8th St. 1
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME PAUL MAX

3. (b) If veteran, name war no

3. (c) Social Security No.

4. Sex Male 0

5. Color or race white

6. (a) Single, widowed, married, divorced widower 2

6. (b) Name of husband or wife Katie Max

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

7. Birth date of deceased Apr (Month) 12 (Day) 1858 (Year)

8. AGE: Years 87 ~~88~~ Months 10 Days 24 If less than one day hr. min.

9. Birthplace Germany (City, town, or county) 4 (State or foreign country)

10. Usual occupation Coffee Salesman 1

11. Industry or business

FATHER
12. Name Unknown 4
13. Birthplace Germany (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Unknown 4
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant Jacob J. Nauedt 1
(b) Address 7351 Sharp Av.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3-11-46 (Month) (Day) (Year)
(c) Place: burial or cremation Mo. Crematory

18. (a) Signature of funeral director Witt Bros. Lt. Hde.
(b) Address 2929 S. Jefferson Av.

19. (a) MAR 11 1946 (Date received local registrar) (b) J. H. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6th year 1946 hour 1:10 minute P M.

21. I hereby certify that I attended the deceased from 2/24/46, 19, to 3/6/46, 19; that I last saw him alive on 3/6/46, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 0

23. Signature 1515 Lafayette 3/9/46 (M.D. or other)

Address R. R. Schladtman Date signed

(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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 2929 So. Jefferson

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.

2B
-41
7852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2346

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH:

(a) County: St Louis

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

(c) Name of hospital or institution: St Louis City Hospital (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 ____ (b) County ____

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

(d) Street No. ____ (If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME: Paul Max

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife ____

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

7. Birth date of deceased: 4 (Month) – 12 (Day) – 1853 (Year)

8. AGE: Years: 87 | Months: 10 | Days: 24 | If less than one day: ____ hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER

12. Name ____

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

14. Maiden name ____

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

16. (a) Informant ____

(b) Address ____

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

(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____

(b) Address ____

19. (a) 3-11-46 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MAR 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 6 year 1946 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw him alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (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 ____ (M. D. or other) ____

Address ____ Date signed ____

SUPPLEMENTARY

11429