

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED JUL 12 1946 STANDARD CERTIFICATE OF DEATH
1003

State File No. **21931**
Registrar's No. **5795**

Registration District No. **318** Primary Registration District No. _____

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:
City Hospital 0
(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 _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3424 McKean**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Margaretta Kunderer**
3. (b) If veteran, name war **--** 3. (c) Social Security No. **--**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **30**
year **1946** hour **5** minut **4** M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Carl**
6. (c) Age of husband or wife if alive **--** years

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

7. Birth date of deceased **March 18 1863**
(Month) (Day) (Year)

Immediate cause of death **Compound Fracture of Left Leg, Fractured Left Wrist, Multiple Abrasion of Forehead, Eye Dead, Puncture Wound Disposed of from Second Floor Window Other Page 3424 McKean Ave June 30 1946 at about 5:00 a.m.**
Duration of illness _____
Other conditions _____ (Include pregnancy within 3 months of death)

8. AGE: Years **83** Months **3** Days **12** If less than one day _____ hr. _____ min.

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation **Home**
11. Industry or business _____
12. Name **Unknown Schwarzmann**
13. Birthplace **Unknown** **Germany 4**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** **Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Kunderer**
(b) Address **3424 McKean**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident**
(b) Date of occurrence **June 30, 1946**
(c) Where did injury occur **at home**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**

17. (a) **Burial** (b) Date thereof **7/3/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

23. Signature **Arthur E. Taylor** (M. D. or other) _____
Address _____ Date signed **7/1/46**

(c) Place: burial or cremation **N. SS Peter & Paul**
18. (a) Signature of funeral director **Wacker-Milde**
(b) Address **3634 Gravois Ave.**
19. (a) **JUL 1 1946** (b) **J. F. Brudersack**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 Robert C. Wheeler
Licensed Embalmer No. 2178
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.