

S. No. 2  
M-5-43  
5-17-39  
-I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25548  
Registrar's No. 6557

FILED AUG 5 1946  
Registration District No. 318  
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, 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 29 days  
(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. 2017  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3225 MONTGOMERY 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PETER MOTL  
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 SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 2- 1860  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 23  
year 1946 hour 5:55 minute P M.  
21. I hereby certify that I attended the deceased from June 22  
\_\_\_\_\_, 1946, to July 23, 1946.  
That I last saw him alive on July 23, 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
86 6 21 hr. min.

Immediate cause of death Localized Purpura  
Due to Splenic Abscess - Cause not known  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) 75  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation LABORER  
11. Industry or business \_\_\_\_\_  
12. Name UNKNOWN  
13. Birthplace \_\_\_\_\_  
14. Maiden name UNKNOWN  
15. Birthplace \_\_\_\_\_

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

16. (a) Informant JOSEPH DWYER  
(b) Address 3225 MONTGOMERY  
17. (a) BURIAL (b) Date thereof 7-26-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CALVARY  
18. (a) Signature of funeral director Gullen Kelly  
(b) Address 4386 Lindell  
19. (a) JUL 26 1946 (Date received local registrar)  
J. F. Braddock (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)  
(e) Means of injury \_\_\_\_\_  
23. Signature Kenneth J. Carter M.D. (M. D. or other) 9/24/46  
Address 1515 Lafayette Avenue Date signed \_\_\_\_\_

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**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 *Frederick H. Guffey*.....

Licensed Embalmer No. *4091*.....

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.**