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17-39
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FILED JUL 22 1946

Registration District No. _____ Primary Registration District No. **1003**

WRITE MAINLY—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: **3327 Pestalozzi /**
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **79 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____
(c) City or town **St. Louis** **16**
(If outside city or town limits, write "RURAL")
(d) Street No. **3327 Pestalozzi**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Pauline Weil Wallstein**

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

4. Sex **F** / 5. Color or race **W**
6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife **Julius Wallstein** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **3** (Month) **26** (Day) **1860** (Year)

8. AGE: Years **86** Months **3** Days **13** If less than one day hr. min.

9. Birthplace: **Austria** (City, town, or county) (State or foreign country)

10. Usual occupation: **at home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Leopold Weil** **4**

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

14. Maiden name **Anna Freund**

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

16. (a) Informant **Josephine Wallstein**

(b) Address **3327 Pestalozzi**

17. (a) **Burial** (b) Date thereof **7/19/46** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **mt Sinai**

18. (a) Signature of funeral director **Waver**

(b) Address **4356 Lindell**

19. (a) **JUL 9 1946** (Date received local registrar) (b) **J. T. Bredbeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **9th** year **1946** hour **2:15** minute **2** M.

21. I hereby certify that I attended the deceased from **Jan 13**, 19**46** to **July 9**, 19**46** that I last saw ~~her~~ alive on **July 8**, 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary thrombosis** Duration **6 wks**

Due to **arteriosclerosis** **1 year**

Due to **hepatitis** **6 yrs**

Other conditions: **renal stenosis**

Major findings: Of operations _____ Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 **Howard Neal** (M-D or other) **B**
Address **3903 Glen St.** Date signed **July 9, 1946**

1946

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 *Albert G. Skapp*

Licensed Embalmer No..... *2971*

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.

Registration District No. 218

Primary Registration District No. 1003

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:

(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)

3. (a) PRINT FULL NAME Pauline V. Wallsten

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased mar 26
(Month) (Day) (Year)

8. AGE: Years 86 Months..... Days..... (less than one day).....
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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) 7-24-'46 (b) J. J. Predest
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....
year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
to.....
that I last saw him/her alive on.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to Nephritis (one year) is considered Chronic.

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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 H.W. Soper (M. D. or other)
Address 3903 Olive St. Date signed.....

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

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