

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS STATE BOARD OF HEALTH OF MISSOURI  
**FILED AUG 27 1946 STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
Registrar's No. 7097

Registration District No. 318 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:  
3151 California Ave.  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Life 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. 3151 California Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Adele Liesring  
(b) If veteran, name war None  
(c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 14  
year 1946 hour 2 minute 35 P.M.  
21. I hereby certify that I attended the deceased from Aug 14 - 1946  
to Aug 13 - 1946  
that I last saw h 2 alive on Aug 13  
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
(b) Name of husband or wife Louis Liesring alive ----- years  
7. Birth date of deceased February 27 1871  
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis Decompenst  
Due to Chr Endo Cardit  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
75 5 17 hr. min.

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name Adolph Hanstein

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

14. Maiden name Unknown

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

16. (a) Informant Miss Edna Cassady

(b) Address Koch Hospital

17. (a) Burial (b) Date thereof 8-16-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old St. Marcus Cem.

18. (a) Signature of funeral director Kingshannon Mortuary

(b) Address 4228 S. Kingshighway

19. (a) AUG 15 1946 (Date received local Registrar)  
J. F. Bradeck (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 Mad J. Slom (M. D. or other)  
Address 500 Oak St. Date signed 8/15/46

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

27623

3550 Hamilton Ave 2720.  
11 Feb 3 PM.

**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 Richard W. Storrson

Licensed Embalmer No. 4009

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.**