

No. 2
-5-43
-5-17-39
I X38671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 15 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38235

Registration District No. 317

Primary Registration District No. 6076

State File No. _____

Registrar's No. 3262

1. PLACE OF DEATH:

(a) County ST LOUIS

(b) City or town PINE LAWN MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
MOTHER OF GOOD COUNSEL HOME
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 YEARS
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST LOUIS 96

(c) City or town PINE LAWN MO
(If outside city or town limits, write "RURAL")

(d) Street No. MOTHER OF GOOD COUNSEL HOME
6825 NATL BRIDGE RD
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANCES HARTUNG

3. (b) If veteran, name war _____

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8th
year 1946 hour 11:00 minute --- P.M.

21. I hereby certify that I attended the deceased from 8/25/1938
8/25/1938 to 11/8/1946
that I last saw her alive on 11/7/1946
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife FRANK HARTUNG

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

7. Birth date of deceased DEC 20 1874
(Month) (Day) (Year)

Immediate cause of death Multiple Thrombosis Left leg and left arm Duration 1-Mo.

8. AGE: Years 71 Months 10 Days 18 If less than one day 11 hr. _____ min.

Due to Hemiplegia left-Apoplexy Rt. Several Strokes since 9-Yrs.

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

Due to Chr-Arterio-sclerosis- Chr. Hypertension- Endo-carditis Myo-carditis-Mitral insufficiency

10. Usual occupation HOUSEWIFE

Other findings (Include pregnancy within 3 months of death) Decompensated

MOTHER FATHER { 11. Industry or business _____

12. Name ANDREW ZIEROFF

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

14. Maiden name FRANCES RUNG

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

Major findings: Chr-Int-nephritis- Obese and bedfast the past (8) yrs. 1315
Underline the cause to which death should be charged Died in the Home of the Incubated

16. (a) Informant Gen. Kasen Schweitzer

(b) Address 5378 Chippewa St

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) BURIAL (b) Date thereof NOV 11 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

18. (a) Signature of funeral director Walter Jordan

(b) Address 6536 Clayton Rd

While at work? _____ (Specify type of place)

(a) Means of injury _____

19. (a) 11-12-46 (b) Ruth J. Jelland
(Date received local registrar) (Registrar's signature)

Signature Sub. B. Jelland (M.D. or other) _____
Address 3734 - Jennings Road Date signed 11/8/46

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

John J. Deinehy

Licensed Embalmer No. 4194

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.