

FILED JAN 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

42511

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11368

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:
St. Anthony Hospital
 (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 **Ida Holstein**3. (b) If veteran,
name war. **no**3. (c) Social Security
No. **No.**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced. **Widowed**
 6. (b) Name of husband or wife..... **Wm. H. A. Holstein**
 6. (c) Age of husband or wife if
 alive..... years
 7. Birth date of deceased. **October 24 1877**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 2 7 hr. min.

9. Birthplace **Stettin Germany 4**
(City, town, or county) (State or foreign country)10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **August Kopplin**13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)14. Maiden name **Unknown Satz**15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)16. (a) Informant **Otto Holstein**(b) Address **128 E. Arlee ave.**17. (a) **Burial** (b) Date thereof. **Jan. 3, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Mt. Hope Cem.**18. (a) Signature of funeral director **C. Hoffmeister U. & L. Co.**(b) Address **7814 S. Broadway**19. (a) **JAN 3 1947** (b) **J. J. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis 96**
 (c) City or town..... **St. Louis Lemay 00**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **128 E. Arlee ave. N.R. 1**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **31**
 year **1946** hour **10** minute **30 A.** M.

21. I hereby certify that I attended the deceased from
Sept. 30, 19**46** to **Dec. 31**, 19**46**
 that I last saw her alive on **Dec 31**, 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **6 mos.**

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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?
U

While at work? (Specify type of place) (e) Means of injury.....

23. Signature **Durand Benjamin** (M. D. or other) **7th**Address **7430 Virginia Ave** Date signed **12/31/46**

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

Louis C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address: 7814 8th Street

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.