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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1947

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 2277

Registrar's No. 1007

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bethesda 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)

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. 5501 Bancroft
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

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3. (a) PRINT FULL NAME Agnes Braud

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased August 8, 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	5	21	hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name Frank Stepefelt
13. Birthplace Louisiana
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Roder
15. Birthplace Louisiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ydette Mayer
(b) Address 5501 Bancroft

17. (a) Removal (b) Date thereof 1-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Chicago, Illinois

18. (a) Signature of funeral director Southern Funeral home
(b) Address 6322 S. Grand. St. Louis, Mo.

19. (a) JAN 30 1947 (b) J F Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 29th
year 1947 hour 1 minute 30 P M.

21. I hereby certify that I attended the deceased from Oct 18 1946 ~~Jan 29 1947~~ to Jan 29, 1947
that I last saw her alive on Jan 29, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Mesenteric thrombosis	18 hrs.
Due to Senile gangrene left foot arteriosclerosis	2 mo.
Due to Diabetes Mellitus	2 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Amputation of left leg above knee for gangrene
Of autopsy None

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 Max Stockloff (M. D. or other) MD
Address 512 Door Pl Date signed 1/30/47

(Licensed Embalmer's Statement on Reverse Side)

12 to 3

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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 J Wm Antsley

Licensed Embalmer No. 3653

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.