

No. 2
-12-45
5-17-39
K47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2450

State File No. _____

FILED FEB 4 1948

Primary Registration District No. 1003

Registrar's No. 583

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
6500a O'Dell St.
(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 St. Louis

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. 6500a O'Dell St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Josephine Etling

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Charles A. Etling

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased July 3 1880
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>66</u> | <u>6</u> | <u>14</u> | hr. _____ min. _____ |

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

10. Usual occupation At home

MOTHER FATHER

11. Industry or business _____

12. Name Michael Hoffman

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

14. Maiden name Mary (?)

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

16. (a) Informant Chas. A. Etling

(b) Address 6500a O'Dell St.

17. (a) Burial (b) Date thereof 1/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) JAN 18 1948 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17
year 1947 hour 11 minute 18 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____,
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Bronch. Pneumonia
(Bronny)

Due to _____

Due to _____

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____ (Specify type of place) _____

(Specify means of injury) _____

23. Signature [Signature] (M. D. or other) _____

Address [Signature] Date signed 1/18/47

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

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 *Ben E. Hoffman*
Licensed Embalmer No. *4366*
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.