S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3158

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 72

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:
4800 Eichelberger Ave
(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. 4800 Eichelberger Ave
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Elizabeth Stahl

3. (b) If veteran, name war ******

3. (c) Social Security No. ******

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased November 13 1862
(Month) (Day) (Year)

8. AGE: Years 84 Months 1 Days 19 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Thomas Kennedy 4
13. Birthplace Ireland 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Kennah
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mayme Stahl
(b) Address 4800 Eichelberger Ave

17. (a) Burial (b) Date thereof 1-6-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter and Paul

18. (a) Signature of funeral director Ziegenhein Bros.
(b) Address 6409 Gravois Ave

19. (a) JAN 4 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2nd day January
year 1947 hour 2:43 minute P. M.

21. I hereby certify that I attended the deceased from Dec 30, 1946 to Jan 2, 1947, 19
that I last saw her alive on Jan 1, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 dy
Due to	
Due to	
Other conditions Hypertension (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? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address 6811 Gravois Date signed 1/3/47

(Licensed Embalmer's Statement on Reverse Side)

Dr Schneewind
6911 Sussex Ave
Fl. 0034
9 to 10

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 Homer W. Fritz

Licensed Embalmer No. 3882

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.