

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 6 1947
3/7

Registration District No. 317

Primary Registration District No. 3069

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

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town Richmond Heights, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's 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 Aurelia Seligstein

3. (b) If veteran, name war None

3. (c) Social Security No. _____

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Sidney

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Oct. 16 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>4</u>	<u>0</u>	hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER

12. Name Henry Bremer

13. Birthplace Milstadt Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Merod

15. Birthplace Milstadt Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Sidney Seligstein

(b) Address 7130 Natural Bridge

17. (a) Burial (b) Date thereof 2 19 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director: Kriegshauser Und. Co.

(b) Address 4228 So. Kingshighway Bl.

19. (a) 2-19-47 (b) Ruth J. Allen, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 6-C-D

(c) City or town St. Louis Co. 17
(If outside city or town limits, write "RURAL")

(d) Street No. 7130 Natural Bridge 9
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16
year 1947 hour 4 minute 50 p.m.

21. I hereby certify that I attended the deceased from Jan 1, 1947 to Feb 16, 1947
that I last saw her alive on Feb 16, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Urinary Exacerbation
Replumed Bladder
Due to Papillary Carcinoma
of Urinary Bladder.

Due to 52 hrs

Duration
36 hours
36 hours

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

Major findings: Papillary Ca of Bladder.
Of operations Replumed Bladder. Papilla Ca Blad.
Of autopsy Same as cause of death

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 N. H. Kraus, M.D. (M. D. or other)
Address 986 Arcadia Bldg Date signed 2/17/47

MAR 20 1947

APR 2 1947

*W. J. ...
Burial 1349 1:30 PM*

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.....

Licensed Embalmer No.....

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.