

No. 2  
-12-45  
5-17-39  
I X47070

FILED MAR 31 1948

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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:  
Lutheran 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 53 Yrs. 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. 3937a Ashland  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Helena Stindel

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20th.  
year 1947 hour 7 minute :50 P.M.

21. I hereby certify that I attended the deceased from March 3rd  
1947 to March 20, 1947;  
that I last saw her alive on March 19, 1947;  
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Charles Stindel 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased September 3 1876  
(Month) (Day) (Year)

Immediate cause of death Cerebral apoplexy Duration 3 wks

8. AGE: Years Months Days If less than one day

|           |          |           |                |
|-----------|----------|-----------|----------------|
| <u>70</u> | <u>6</u> | <u>17</u> | hr. _____ min. |
|-----------|----------|-----------|----------------|

Due to \_\_\_\_\_

Due to Chronic hypertension hyp

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name John Adam

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

14. Maiden name Pauline Franz

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

16. (a) Informant Mrs. Helen Gotsch

(b) Address 5210 Lindenwood Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47  
(Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Beiderwieden F.H. Inc.

(b) Address 1936 St. Louis Avenue

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

25. Signature: A. M. Grant (M. D. or other) MD  
Address 3651 Maple Date signed 3/21/47

19. (a) MAR 23 1947 (Date received local registrar) (b) J. F. Brueck (Registrar's signature)

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

Dr. A. M. Grant

SEP 8 1948

AUG 24 1948

**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 Walter Paulson

Licensed Embalmer No. 4114

P. O. Address. 1936 St. Louis Ave

**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.**