

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED MAR 31 1947

STANDARD CERTIFICATE OF DEATH

11644

State File No. _____

2833

Registrar's No. _____

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2848 Victor 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 **Mo.** (b) County _____
(c) City or town **St. Louis** **2317**
(If outside city or town limits, write "RURAL")
(d) Street No. **2848 Victor St.** **9**
(If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JULIA C. VITT**

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 **Widow 2**

6. (b) Name of husband or wife **Late John A.** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. **May 30 1871**
(Month) (Day) (Year)

8. AGE: Years **75** Months **9** Days **16** If less than one day hr. _____ min. _____

9. Birthplace **Washington Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Anton Zoff**

13. Birthplace **Italy 5**
(City, town, or county) (State or foreign country)

14. Maiden name **Cecelia Beyreis**

15. Birthplace **Washington Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Harry Schuenemeyer**

(b) Address **2848 Victor St.**

17. (a) **Removal (Mtr.)** (b) Date thereof **3 19 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington, Mo.**

18. (a) Signature of funeral director **Kriegshauser Und Co.**
(b) Address **4228 So. Kingshighway Bl.**

19. (a) **MAR 17 1947** (b) **J. T. Budack**
(Date received local file) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **16th**
year **1947** hour **11:55** minute _____ A.M.

21. I hereby certify that I attended the deceased from **Nov 29** 19**46** to **Feb 16** 19**47**
that I last saw her alive on **Nov 29** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Liver**
Due to **Carcinoma of Rectum**
Due to **Cancer**
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
1 year

Major findings: **Cancer Rectum**
Of operations _____
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 **E. C. Reyes** (M. D. or other) _____
Address **4952 Maryland St.** Date signed **3-17-47**

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

MOTHER FATHER

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..... *Richard W. Stovesand*

Licensed Embalmer No..... *4007*

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.

Registration District No. 318

Primary Registration District No. 1003

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: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Julia C. Witt

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: May 30 (Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ (unless than one day) hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Brebeck (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 194 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. _____
Duration _____
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (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? _____

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

APR 3 1947

11644