

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11881⁰¹

FILED MAR 21 1947

State File No. _____
Registrar's No. 647

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Shamrock Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 9135 Chestnut St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sophia Apperson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 17 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Oct 15 1946 to Mar 17 1947.
that I last saw her alive on March 14 1947 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W
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 109 1750 1876
(Month) (Day) (Year)

Immediate cause of death _____
Chr. Myocarditis
Due to Genl arteriosclerosis
Diabetes Mellitus
Due to Arterio Sclerotic Abnormalities
Structure of Heart - Ca. (old) heard
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
70 5 17 hr. _____ min. _____

Major findings: Coronary-fov. Arterial Structure
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace Haver, Wash. Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name Wm. Drafte

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

14. Maiden name Emma Falzel

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

16. (a) Informant Geneva Apperson

(b) Address St. Louis, Mo.

17. (a) _____ (b) Date thereof 3/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Trinity

18. (a) Signature of funeral director St. Trinity

(b) Address 7420 Michigan Ave

19. (a) 3-21-47 (b) Althoff
(Date received local Registrar) (Registrar's signature)

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 Chas. Thoenberger (M. D. or other) _____
Address 7745 Olive St Date signed 3/17/47

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

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APR 16 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..... *Oliver E. Fendler*

Licensed Embalmer No. *41748*

P. O. Address..... *Longview*

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.