

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED APR 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15765
Registrar's No. 3724

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: 5011 Goethe Ave.
(d) Length of stay: In hospital or institution.
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis
(d) Street No. 5011 Goethe Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JOHANNA WAHLIG
3. (b) If veteran, name war None
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 7
year 1947 hour 7:40 minute A.M.
21. I hereby certify that I attended the deceased from April 3, 1947, to April 7, 1947
that I last saw her alive on April 6, 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
6. (b) Name of husband or wife Frank
6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased June 10 1884
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension & Acute Parenchymatous Nephritis
Due to Diabetes
Other conditions
Major findings: Of operations
Of autopsy
Duration 4 days
2 yrs
2 years

8. AGE: Years Months Days
62 9 27
If less than one day hr. min.

9. Birthplace Jefferson Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business

MOTHER FATHER
12. Name Wolfgang Steckel
13. Birthplace Germany
14. Maiden name Unknown
15. Birthplace Germany

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

16. (a) Informant Frank Wahlig
(b) Address 5011 Goethe Ave.

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

17. (a) Entombment (b) Date thereof 4 10 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Mausoleum
Kriegshauser Und. Co.

18. (a) Signature of funeral director
(b) Address 4228 So. Kingshighway Bl.

While at work? (Specify type of place)
(c) Means of injury
23. Signature Walter Friedman (M.D. or other)
Address 3146 Morganford Date signed Apr 8 47

19. (a) APR 8 1947 (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

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

0-2
1-45
7-39
K47070

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.....

Edwin M. Perinatt

Licensed Embalmer No. *3024*

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.