

No. 2  
1/47  
6-17-39

National Office of Vital Statistics

FILED MAY 29 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2974

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

1. PLACE OF DEATH:

(a) County MISSOURI

(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
3756 MICHIGAN  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community 40 YRS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 3756 MICHIGAN  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Sophie E. Lodewyck-Holman

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 16  
year 1947 hour 12 minute 01 A.M.

4. Sex FEMALE 5. Color or race WHITE

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 SEPT. 28 1886  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 16 1947 to May 16 1947  
that I last saw her alive on May 14 1947  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>7</u>	<u>18</u>	hr. min.

Immediate cause of death  
Chronic myo. carditis @ C  
Interal stenosis

Due to Rheuma. Fc heart diseases.

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

10. Usual occupation HOUSEWIFE

11. Industry or business AT HOME

12. Name PAUL FUNK

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

14. Maiden name UNKNOWN

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

Other conditions circosis of liver @ C  
arteries

Due to.....

Due to.....

16. (a) Informant HENRY LODEWYCK  
(b) Address 3756 MICHIGAN

17. (a) BURIAL (b) Date thereof MAY 19, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VAL HALLA CEM.

18. (a) Signature of funeral director Thomas Kutin & Son  
(b) Address 2906 GRAKOLS

19. (a) MAY 16 1947 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)..... no

(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 [Signature] (M. D. or other).....  
Address 3804 Wilmington Ave Date signed 5-16-47

Duration many  
years.

swind  
months.

PHYSICIAN

Underline the cause of which death should be charged statistically.

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 Harold C. Hill

Licensed Embalmer No. 4347

P. O. Address 2901 Lewis

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 318Primary Registration District No. 1003Registrar's No. 4974

## 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 \_\_\_\_\_  
years, months or days3. (a) PRINT FULL NAME Sophie E. Holman

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
- Widow

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

7. Birth date of deceased
- Sept 28
- 
- (Month) (Day) (Year)

8. AGE: Years
- 60
- Months
- 7
- Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

## 10. Usual occupation \_\_\_\_\_

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

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. Bradack
- 
- (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
- June
- 19
- 46
- 
- year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Date signed \_\_\_\_\_

Duration

## PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

JUN 17 1946

S-18949

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