

FILED MAY 29 1947

318

1003

State File No. \_\_\_\_\_

Registrar's No. 5078

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:  
Alexian Bros. Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 1/2 days  
(Specify whether years, months or days)  
 In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oaw  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3138 Illinois Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18  
 year 1947 hour 12 minute 40 M.

21. I hereby certify that I attended the deceased from  
March 12 1947 to 18 May 1947  
 that I last saw him alive on May 18 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Apoplexy Duration 1 hour

Due to: Cardiovascular disease with hypertension  
 Due to: Arteriosclerosis 6 yrs  
20 yrs

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 Mitchell L. Bartnick (M. D. or other) M. D.  
 Address 7629 So. Broadway Date signed 5/18/47

3. (a) PRINT FULL NAME JULIUS STUPP SR.

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Ida, nee Bieger 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased July 8 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>10</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation Retired Sec'y-Treas.

11. Industry or business Stupp Bros. Bridge & Iron Co.

12. Name John Stupp

13. Birthplace \_\_\_\_\_ Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Falkenhainer

15. Birthplace \_\_\_\_\_ Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Arthur Stupp

(b) Address 3629 Arkansas

17. (a) Burial (b) Date thereof May 21, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthew Cemetery

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

(b) Address 1936 St. Louis Ave.

19. (a) MAY 21 1947 (b) J. F. Breda  
(Date received local registrar) (Registrar's signature)

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.....

*Glenn W. Hay*

Licensed Embalmer No.....

*3737*

P. O. Address.....

*1936 W. Lu...*

**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.**