

No. 2  
5-543  
5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19720  
Registrar's No. 1147

FILED JUN 18 1947  
Registration District No. 1517

Primary Registration District No. 4467

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Waller Park Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
MOLL NURSING HOME 4  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution APR. 14<sup>th</sup> to June 6<sup>th</sup>  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis <sup>800</sup>

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") <sup>17</sup>

(d) Street No. 4985 OLETHA AVE  
(If rural, give location) <sup>9</sup>

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) <sup>4</sup>

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lottie Kirckhoff

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6<sup>th</sup>  
year 1947 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from Apr. 14 1947 to June 6 1947.

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
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, widowed

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

7. Birth date of deceased SEPT 10 1873  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration 9 da

Due to Acute Bronchitis  
Hypertensive Cardio-renal disease  
Advanced arteriosclerosis

Due to 131c

8. AGE: Years Months Days If less than one day

73 8 26 hr. min.

9. Birthplace Sweden 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

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

12. Name Christ Anderson

13. Birthplace Sweden 4  
(City, town, or county) (State or foreign country)

14. Maiden name Ida Unknown

15. Birthplace Sweden 4  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant SEP. L. POTIER

(b) Address 4985 OLETHA AVE. ST. LOUIS, MO.

17. (a) Removal (Rail) (b) Date thereof 6 7 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Ill.

18. (a) Signature of funeral director Kriegshauser Und. Co.

(b) Address 4228 So. Kingshighway Bl.

19. (a) 6-9-47 (b) Ben A. Z...  
(Date received local registrar) (Registrar's signature)

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 0

23. Signature Walter Groves (M. D. or other) 748

Address Webster Groves Mo. date signed 6/7/47

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, *Edmund J. McDermott*

Licensed Embalmer No. *3074*

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.**