

No. 2
-12-45
5-17-39
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22682

FILED JUL 7 1947

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 2131

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: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(Specify whether
In this community 89 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County St. Louis
(b) City or town St. Johns
(If outside city or town limits, write "RURAL")
(c) Street No. 8819 North Avenue
(If rural, give location)
(d) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EMIL STEMMLER

3. (b) If veteran, name war None
3. (c) Social Security No. None

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

6. (b) Name of husband or wife Margaret O'Brien
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 8, 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 9 17
hr. min.

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

10. Usual occupation Retired watchman

11. Industry or business _____

12. Name Philip Stemmler

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)

16. (a) Informant Mrs. Anna Jordan

(b) Address 8819 North Ave., St. Johns

17. (a) Burial (b) Date thereof 6-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. J. Reed
(b) Address 2117 East Grand Blvd.

19. (a) JUN 27 1947 (b) Registrar's signature J. J. Reed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25th
year 1947 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 fracture of right hip
interosseous when he fell
June 21, Charles Oak Road
9000 Block R) where he slipped
and fell on June 16, 1947 about
4:20 P.M.

Other conditions (Include pregnancy within 3 months of death) 186

Major findings: Of operations 27

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence June 18 1947

(c) Where did injury occur? St. Johns County
(City or town) (County) (State)

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

While at work? _____ (Specify type of place) _____
Means of injury Automobile

23. Signature Walter D. Perry (M. D. or other) _____
Address Deputy Registrar Date signed 6/27/47

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

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 Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. 1st St.

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.