V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 15 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26102

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 7425

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: Missouri Pacific Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 500

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

(d) Street No. 4359 Taft Ave (If rural, give location) 9

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Stohlman Charles Henry

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

3. (c) Social Security No. --

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anna Stohlman

6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased 8/15/1866 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
80	11	21	3 hr. 55 min.

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

10. Usual occupation Retired

11. Industry or business Operation Dept Mo. Pac R.R.

FATHER
12. Name John R. Stohlman
13. Birthplace Washington (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant W. D. Stohlman

(b) Address 4524a Gibson Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Robert J. Ambruster Inc

(b) Address 6633 Clayton Road

19. (a) AUG 7 1947 (Date received local registrar) (b) J. A. Bielecke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6 year 1947 hour 3 minute 55 A.M.

21. I hereby certify that I attended the deceased from July 13, 1947, to Aug 6, 1947, that I last saw him alive on Aug 6, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, Hypostatic — Duration 5

Due to: 2

Due to: 1

Other conditions (Include pregnancy within 3 months of death): Fractured left hip — 1

Major findings: Of operations: 8

Of autopsy: No autopsy

PHYSICIAN — Underline the cause of which death should be charged statistically.

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

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

(b) Date of occurrence First week in June 1947

(c) Where did injury occur? In his home (City or town) (County) (State)

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

While at work? No (Specify type of place) (e) Means of injury Fall from bed

23. Signature Vincent A. Sherrod (M. D.)

Address Mo. Pac. Hosp. Date signed 8-6-47

VINCENT A SHERROD

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

Reg Com - 8-11-47

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo

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.