No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 21 1947
#72681

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29458
7758

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 60 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2124 Cushing (If rural, give location)
23
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MINNIE ROBERT
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 W
6. (b) Name of husband or wife Rail
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 6 (Day) 1867 (Year)

8. AGE: Years 80 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Germany (City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name not Known
13. Birthplace Germany (City, town, or county) (State or foreign country)

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

16. (a) Informant Arthur Robert
(b) Address 6744 Neosho
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-47 (Month) (Day) (Year)
(c) Place: burial or cremation N. St. Marcus
18. (a) Signature of funeral director John L. Zegenhein & Son
(b) Address 7027 Gravois
19. (a) AUG 13 1947 (Date received by registrar) (b) Jos. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 12th year 1947 hour 5:20 minute P M.
21. I hereby certify that I attended the deceased from 6/25/47, 19..., to Aug. 12th, 19 47 that I last saw her alive on Aug. 12th, 19 47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia Bron	2 days
Due to Post-amputation - rt mid-thigh	4 days
Due to Arteria sclerotic gangrene rt foot	3 mo.
Other conditions (Include pregnancy within 3 months of death) b. Arteria sclerotic Heart disease	

Major findings:
Of operations
Of 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)
(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 Peter Ph. Bruce 8/13/47 (M. D. or other)
Address 1515 Lafayette Date signed

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

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 Owen.....

Licensed Embalmer No. 2245

P. O. Address 702 7 Francis

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.