

B. No. 2
1-1/47
5-17-39

FILED OCT 11 1947

Registration District No. **14081 318** Primary Registration District No.

1003

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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3529 Arsenal St.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **FRED HEIDOLPH**
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 **married**
6. (b) Name of husband or wife **Bertha Heidolph**
6. (c) Age of husband or wife if alive **74** years
7. Birth date of deceased **April 28th 1865**
(Month) (Day) (Year)

8. AGE: Years **82** Months **5** Days **6**
If less than one dayhr.min.

9. Birthplace **Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Janitor**

11. Industry or business.....

12. Name **William Heidolph**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Magdalena Viegelmasser**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bertha Heidolph**

(b) Address **3529 Arsenal St.**

17. (a) **burial** (b) Date thereof **10-7-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Ziegenhein Bros.**

(b) Address **6409 Gravois Ave.**

19. (a) **OCT 6 1947** (b) **J. F. Bressek**
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **4th**
year **1947** hour **12:45** minute **P.** M.
21. I hereby certify that I attended the deceased from **10-2-47**
....., 19..... to **10-4-47**, 19.....
that I last saw him alive on **10-4-47**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia, lobar**
Duration **1 wk.**

Due to **106**
Due to.....

Other conditions **Hypertension**
(Include pregnancy within 6 months of death)
cardiovascular 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 **0**

23. Signature **J. F. Bressek, M.D.** (M. D. or other).....

Address **1515 Lafayette** Date signed **10-6-47**

WRITE PLAINLY—USING 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.....

Homer W. Fitch

..... Licensed Embalmer No..... *3882*

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.