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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40169**
Registrar's No. **10551**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 hours**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Bertha Seidenkranz.**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced. **Widowed**
6. (b) Name of husband or wife **Louis Seidenkranz.**
6. (c) Age of husband or wife if alive **Dec'd.** years
7. Birth date of deceased **August 28, 1876.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 **2** **16** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Dont know.** **9**

13. Birthplace **Dont know.** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Dont know.** **9**

15. Birthplace **Dont know.** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ethel Maxwell.**

(b) Address **Route 7 Box 735 Overland, Mo.**

17. (a) **Burial** (b) Date thereof **11-17-1947.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lake Charles Cemetary.**

18. (a) Signature of funeral director **Geo. L. Pleitsch, Inc.**

(b) Address **5966-68 Easton Avenue.**

19. (a) **NOV 17 1947** (b) **J. F. Bradeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis 96**
(c) City or town **Overland** **0**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 7 Box 735** **0**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **November** day **14th.**
year **1947** hour **11** minute **10 P.** M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pulmonary Embolism; Fracture of left Femur; CAUSE AND MANNER OF SAME COULD NOT BE DETERMINED.

Due to _____
OPEN VERDICT

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

195
99

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

(a) Accident, suicide, or homicide (specify) **OPEN VERDICT** **000**

(b) Date of occurrence **See above**

(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?
unknown

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

23. Signature **[Signature]** (M. D. or other) **See Above**

Address **[Signature]** Date signed **11/17/47**

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

MOTHER FATHER

Handwritten mark

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 *Clement M. Mc Neary*.....

Licensed Embalmer No. *3732*.....

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.