

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2509

FILED FEB 9 1948 318

State File No. _____

Registration District No. _____ Primary Registration District No. _____

1003

Registrar's No. 928

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:
Deaconess Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Robert H. Flader

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased September 30 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 3 29 10 hr. 00 min.

9. Birthplace Breeze Ill
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Physician

MOTHER FATHER

12. Name Ferdinand Flader

13. Birthplace Stattin Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Alvina Baum

15. Birthplace Stattin Germany 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. J. Kunz

(b) Address 318 Bompert Ave

17. (a) Burial (b) Date thereof 1/30/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cemetery

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

(b) Address 6633 Clayton Road

19. (a) JAN 30 1948 J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96
(c) City or town Webster Groves 7
(If outside city or town limits, write "RURAL")
(d) Street No. 26 Summitt Ave 4
N.R. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 29th
year 1948 hour 10 minute A M.

21. I hereby certify that I attended the deceased from 1/10/48
to 1/29/48 19...;
that I last saw h. im alive on 1/29/48 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure 19 Days
Duration

Due to Hypertensive Cardio Vascular Renal Disease 6 Yrs
Due to Generalized Arteriosclerosis 6 Yrs

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

Major findings: _____
Of operations _____

Of autopsy _____

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?

While at work? _____ (Specify type of place)
(e) Means of injury 0

23. Signature Charles C. Drace (M. D. or other) _____
Address 19 E. Lockwood Ave Date signed 1/29/48

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

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

FEB 18 1948

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.