

No. 300  
-10-47  
5-17-39  
1-3908

FILED APR 7 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3156

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:  
3834 ARSENAL ST. 1  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_

(c) City or town ST LOUIS 17  
(If outside city or town limits, write "RURAL" \_\_\_\_\_)

(d) Street No. 3834 ARSENAL ST. 9  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BEATRICE Kung Mitchell

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex FE 1

5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased FEBRUARY 27 1883  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30  
year 48 hour \_\_\_\_\_ minute 4 P. M.

21. I hereby certify that I attended the deceased from Feb.  
1 1948 to Mar. 30 1948  
that I last saw he alive on Mar. 29 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Endocarditis. 10 yrs  
Duration

8. AGE: Years 65 Months 1 Days 3  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Rheumatic fever,

Due to \_\_\_\_\_

9. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

10. Usual occupation BEAUTY Shop,

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business OWNER

12. Name FRED PELLIN

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

14. Maiden name LENA TESSIN

15. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations none

Of autopsy none

16. (a) Informant Frank Kunz,

(b) Address 4643 Ashland Av

17. (a) CREMATION (b) Date thereof April 2-48  
(Funeral, cremation, or recovery) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

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? \_\_\_\_\_

18. (a) Signature of funeral director E. J. Schmur

(b) Address 3125 Lafayette Av

19. (a) MAR 31 1948 (Date received local registrar)

J. F. Bredeck (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(a) Means of injury ○

23. Signature Dr. L. H. Koch (M. D. or other) \_\_\_\_\_

Address 1504 S. Grand Date signed 3/30/48

WRITE PLAINLY—USE 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

*Van Sigemore*

Licensed Embalmer No.

*4343*

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.**

Registration District No. 318

Primary Registration District No. 1003

**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:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether

**2. USUAL RESIDENCE OF DECEASED:**

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

**3. (a) PRINT FULL NAME** Beatrice K. Mitchell  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month.....  
 year 1945 hour..... minute..... M.  
 21. I hereby certify that I attended the deceased from..... to....., 19.....  
 that I last saw him..... alive on....., 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

4. Sex..... F 5. Color or race..... W  
 6. (a) Single, widowed, married, divorced..... Widowed  
 6. (b) Name of husband or wife..... Henry  
 6. (c) Age of husband or wife if alive..... 27  
 7. Birth date of deceased..... Sept 27  
(Month) (Day) (Year)

**8. AGE:** Years..... 65 Months..... Days.....  
If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

**MOTHER** { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b) J. F. Busch  
(Date received local registrar) (Registrar's signature)

Due to.....

Due to.....

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

23. Signature..... L. H. Bock (M. D. or other).....

Address..... Date signed.....

**SUPPLEMENTARY**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-16490

0-866-26