No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 30 1948
Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 14066
Registrar's No. 3833

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

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: LUTHERAN HOSPITAL
(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 MISSOURI (b) County add
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1816 S. 12th 9
(If rural, give location)
(e) Citizen of foreign country? 23 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MINNIE FECKAR
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of ~~husband or wife~~ LEO
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased JULY (Month) 27 (Day) 1890 (Year)

8. AGE: Years 57 Months 8 Days 25 If less than one day hr. min.

9. Birthplace WISCONSIN (City, town, or county) (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business AT HOME
FATHER
12. Name ERNST SCHULZ
13. Birthplace GERMANY (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name UNKNOWN
15. Birthplace GERMANY (City, town, or county) (State or foreign country)
16. (a) Informant LEO FECKAR
(b) Address 1816 S. 12th
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 24 1948 (Month) (Day) (Year)
(c) Place: burial or cremation NATIONAL CEM. JEFF BAKS.
18. (a) Signature of funeral director Thomas Kutis + Son
(b) Address 2906 GRAVOIS
19. (a) APR 22 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 21 year 1948 hour 6 minute 50 P. M.
21. I hereby certify that I attended the deceased from 5/4/46, 19, to 4/21/48, 19; that I last saw her alive on 4/21/48, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Coronary Thrombosis	1 Day
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations NONE	
Of autopsy NONE	

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 CE Steindel (M. D. or other) M. D.
Address 3701 Grendel Sq. Date signed 4/22/48

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.....

Licensed Embalmer No.....

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.

S. No. 2B
—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

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

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 Lutheran Hospital
(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)

In this community

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 Minnie Feckar

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 Married

6. (b) Name of husband or wife Leo

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased July - 27 - 1890
(Month) (Day) (Year)

8. AGE: Years 57 Months 8 Days 25 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4-22-48 (Date received local registrar) (b) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , 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 — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-14066