FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 28 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24607

Registration District No. 318 — Primary Registration District No. 1005 — Registrar's No. 6419

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: 3321 S. 13th ST.
(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) 1
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: 009
(c) City or town: ST. LOUIS 9
(If outside city or town limits, write "RURAL")
(d) Street No.: 3321 S. 13th ST.
(If rural, give location) 24
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Josephine M. Peetz
3. (b) If veteran, name war
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~~: JOHN
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: July (Month) 16 (Day) 1872 (Year)

8. AGE: Years 76 | Months 0 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace (City, town, or county) (State or foreign country): MO
10. Usual occupation: WIDOW
11. Industry or business: AT HOME
MOTHER FATHER
12. Name: EMIL RECKERT
13. Birthplace (City, town, or county) (State or foreign country): GERMANY
14. Maiden name: MARY DIEDRICH
15. Birthplace (City, town, or county) (State or foreign country): GERMANY
16. (a) Informant: MRS. EBER SIMPSON
(b) Address: 3756 POTOMAC
17. (a) Burial, cremation, or removal: BURIAL (b) Date thereof (Month) (Day) (Year): JULY 21, 1948
(c) Place: burial or cremation: CALVARY CEM.
18. (a) Signature of funeral director: Thomas Kutis & Son
(b) Address: 2906 GRAVOIS
19. (a) Date received by local registrar: JUL 20 1948 (b) Registrar's signature: J. F. Bredeck

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1948 hour 8 minute A.M.
21. I hereby certify that I attended the deceased from June 15, 1946 to July 19, 1948; that I last saw her alive on 7/19, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	30 hrs
Due to: Hypertension	2 years
Due to: Aterio sclerosis general	2 years
Other conditions (Include pregnancy within 3 months of death):	
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
23. Signature: Eber Simpson (M. D. or other) M.D.
Address: 3739 Gravois Date signed: 7/19/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Hamer C. Mill

Licensed Embalmer No. 4347

P. O. Address 2906 Travis

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.

No. 2B
—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 449

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 649

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 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 Josephine M. Peetz

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased July 16 1873
(Month) (Day) (Year)

8. AGE: Years 76 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 9 year 1948 hour minute 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.

	Duration
Immediate cause of death	
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

5-24607