#88716

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27818

FILED SEP 13 1948

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7689

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

1. PLACE OF DEATH:
(a) County
(b) City or town St.Louis,Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St.Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution one day
In this community unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St.Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1500 Arsenal -City Infirmary
(If rural, give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME GERTRUDE HOFELDT
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 unknown
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased February (Month) 21st (Day) ? (Year)

8. AGE: Years abt-62 Months Days If less than one day hr. min.

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

10. Usual occupation
11. Industry or business Nil

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

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant M.Renard
(b) Address St.Louis City Hospital

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof AUG 31 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service
(b) Address 4104 Manchester Ave.

19. (a) AUG 31 1948 (Date received local registrar) J. F. Meneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20th year 1948 hour 11 minute 20 P M.

21. I hereby certify that I attended the deceased from 8/20/48, 19 , to Aug 20th, 1948 that I last saw her alive on Aug 20th, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Incarcerated Umbilical Hernia	2 days
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 E. H. Caron, M.D. (M. D. or other)
Address 1515 Lafayette Date signed 8/21/48

(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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.