

No. 300
-10-47
5-17-39
P-I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35220**
2264
Registrar's No. _____

Registration District No. **377**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Torrence Nursing Home 128 E. Etta
(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 OTILLIE STENZHORN

3. (b) If veteran, name war None 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 Fred 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 21 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 9 6 hr. min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER

12. Name Frank Glatzel

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

14. Maiden name Anna Stolz

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

16. (a) Informant Mrs. Emma Howard

(b) Address 4329 Duke St.

17. (a) Burial (b) Date thereof 9-30-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Kriegshauser Und. Co.

(b) Address 4228 S. Kingshighway Bl.

19. (a) 9/29/48 (b) Coil A. Ze Sharp
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4329 Duke St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep't. day 27
year 1948 hour 9:20 minute _____ A. M.

21. I hereby certify that I attended the deceased from 29 July, 1948, to 27th Sept, 1948,
that I last saw her alive on 26 Sept, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 3 mos

Due to arteriosclerotic heart disease

Other conditions 93d
(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 William F. Williams (M. D. or other) M.D.
Address 7619a Gray Date signed 29 Sept 48

7600 Skuony Ave.

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 Richard W. Stovresand

Licensed Embalmer No. 4007

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.