

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **41830**
Registrar's No. **11343**

Registration District No. **318**

Primary Registration District No. **1003**

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

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: Jewish 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)

3. (a) PRINT FULL NAME ETHEL B. SEHNERT
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 Emil P. 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Nov. 9 1883
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 20 If less than one day 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 Isaac Shafer
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Emil P. Sehnert
(b) Address 4260a Flad Ave.

17. (a) Burial (b) Date thereof 12 31 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem.

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

(b) Address 4228 S. Kingshighway Bl.

19. (a) DEC 29 1948 (b) J. C. Laster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County San
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4260a Flad Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29
year 1948 hour 7:45 minute A. M.

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

Immediate cause of death Acute Peritonitis

Due to intestinal obstruction
Perforation of colon
Carcinoma of colon

Other conditions Hypertensive heart disease

Major findings of operations as above
Of autopsy as above

Duration _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Frank A. Fairbank (M. D. or other) MD
Address 461 North Taylor Date signed 12/29/48

462 Mr Taylor
V-3

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. Stovesand

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.