S. No. 300
Rev. 10.48

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

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28537

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 100 Registrar's No. 7444

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3546 Tennessee

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 000
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 3546 Tennessee

3. NAME OF DECEASED (Type or Print)
a. (First): Wilheimina
b. (Middle):
c. (Last): Seitrich

4. DATE OF DEATH (Month) (Day) (Year): 8/25/49

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Mar. 6, 1868
9. AGE (In years last birthday): 81 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Leapold Linz
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Henry L. Seitrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Rose Seitrich--3546 Tennessee

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 13 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential Hypertension — 2-3 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 102
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: HHX

22. *I hereby certify that I attended the deceased from* Aug 13, 1949, *to* Aug 25, 1949, *that I last saw the deceased alive on* Aug 25, 1949, *and that death occurred at* 2:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] M.D.
23b. ADDRESS: 3606 Indiana Ave
23c. DATE SIGNED: 8/26/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/29/49
24c. NAME OF CEMETERY OR CREMATORY: SS Peter & Paul Cem.
24d. LOCATION (City, town, or county) (State): St. Louis, Missouri

DATE REC'D BY LOCAL REG. AUG 27 1949
REGISTRAR'S SIGNATURE: J. B. Sarden
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wacker-Helderle — 3634 Gravois

(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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed Felix J. Krispin

Licensed Embalmer No. 3497

P. O. Address 3634 Gravois

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.