

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32086**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **8255**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8255	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 3719 Louisiana	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3719 Louisiana				d. STREET ADDRESS (If rural, give location) 3719 Louisiana			
3. NAME OF DECEASED (Type or Print) Angela		a. (First)		b. (Middle)		c. (Last) Pevesdorf	
4. DATE OF DEATH 9/24/49		DATE (Month) (Day) (Year)		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) Widow		8. DATE OF BIRTH Aug. 19, 1867		9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months Days Hours Mins.	
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) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Robben		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE William			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. --		17. INFORMANT'S SIGNATURE OR NAME Mrs. M. Nicholson--3719 Louisiana ADDRESS 3719 Louisiana			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stroke Left Hip ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Seriousness of Right Hip DUE TO (c) Paralytic Stroke				C. INTERVAL BETWEEN ONSET AND DEATH 3 days 1 day	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis St. Louis Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 21 1949 P.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Apparently slipped & fell on kitchen			
22. I hereby certify that I attended the deceased from 9/22 19 49 , to 9/24 19 49 , that I last saw the deceased alive on 9/24 19 49 , and that death occurred at 12 noon , from the causes and on the date stated above.							
23a. SIGNATURE J. S. Dunscomb (Degree or title) MD.				23b. ADDRESS 5703 Chippewa		23c. DATE SIGNED 9/24/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/27/49		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	
DATE REC'D BY LOCAL REG. SEP 26 1949		REGISTRAR'S SIGNATURE J. S. Dunscomb		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldler ADDRESS 3634 Gravois			

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

1667

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 *Seliv J. Krupin*
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.