

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003 State File No. 32088
8618

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 1/2 day		d. STREET ADDRESS (If rural, give location) 10 3619 Humphrey St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Josephine Heimkamp Hosp.			

3. NAME OF DECEASED (Type or Print) Catherine Pfeffer			4. DATE OF DEATH (Month) (Day) (Year) 10/5/49		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Mar. 17, 1865		9. AGE (In years last birthday) 84
10a. USUAL OCCUPATION (Give kind of work doing 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 John G. Pfeffer		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE -----	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Roland Ungerman--3619 Humphrey	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Ac Cardiac Failure</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Ac Gastric Hemorrhage</i> <i>Ruptured Gastric Vessel</i> DUE TO (c) <i>Ac Cholelithiasis</i> II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. <i>chronic arthritis</i> <i>a cerebral aneurysm</i>			INTERVAL BETWEEN ONSET AND DEATH 1 Day 1 Day 2 Day 4-5 years
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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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) 97	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4500	

22. I hereby certify that I attended the deceased from 11/16/48 to 10/5/49, that I last saw the deceased alive on 10/4/49, 1949, and that death occurred at 4:50 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George S. McKau, M.D.		23b. ADDRESS 2903 Olive		23c. DATE SIGNED 10/6/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/7/49		24c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL REGISTRY OCT 6 1949		REGISTRAR'S SIGNATURE JOS Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Weldert 3634 Gravois	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Delia 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.