

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21844

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5528**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place) 18 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2249	
		d. STREET ADDRESS (If rural, give location) 3236 1/2 S 13th 0	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Theresa	b. (Middle)	c. (Last) Mundwiller	(Month) June	(Day) 24,	(Year) 1950

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH June 13, 1863	9. AGE (In years) (Specify birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME not known	13b. MOTHER'S MAIDEN NAME not known	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. none	17. INFORMANT'S SIGNATURE OR NAME Mrs Kate Schindler	ADDRESS 2828 Shenandoah
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> Coronary Thrombosis DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

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) 4201 (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from _____ 19____, to _____ 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1:30 A** m., from the causes and on the date stated above.

22a. SIGNATURE Patrick E Taylor Esq	(Degree or title) 3	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 6-26-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 6/27/50	24c. NAME OF CEMETERY OR CREMATORY Old St Marcus Cemetery	24d. LOCATION (City, town, or county) (State) St Louis, Mo.
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DATE REC'D BY LOCAL REG. JUN 26 1950	REGISTRAR'S SIGNATURE J. B. Saxton	25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons	ADDRESS 7027 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 _____

working under my personal supervision.

Student Embalmer No.

Signed

W. G. Peterson

Signed.....
Student Embalmer

Licensed Embalmer No. *3767*

P. O. Address *7027 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.