

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 24 1955

State File No. 35203

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8849			
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. LENGTH OF STAY (In this place) 70 yrs.		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital				e. STREET ADDRESS (If rural, give location) 15 3204a Delor Street 215 10					
3. NAME OF DECEASED (Type or Print) a. (First) ELEANOR			b. (Middle) ANNA		c. (Last) STOLTZE		4. DATE OF DEATH (Month) (Day) (Year) Oct. 10 1955		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 10-4-1885		9. AGE (In years last birthday) 70 yrs 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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Edward Wessler			13b. MOTHER'S MAIDEN NAME Minnie Thomas			14. NAME OF HUSBAND OR WIFE William A. Stoltze			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William A. Stoltze, 3204a Delor Street				
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) Cerebral hemorrhage ANTECEDENT CAUSES Left hemiplegia Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ch. C.V.H. disease & hypertension DUE TO (c) Hypostatic pneumonia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4-5 days						INTERVAL BETWEEN ONSET AND DEATH 8 1/4 days 2-3 1/2 days	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION None 443 x 0.2 x 2.5						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO		21b. PLACE OF INJURY (e.g., in apartment, in car, in street, in building, etc.) 191st. ave. 10/11/55		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis, Mo. 10/11/55					
21d. TIME OF INJURY _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? 10/11/55					
22. I hereby certify that I attended the deceased from 8-4-55 to 10-10-55, that I last saw the deceased alive on 10-10-55, and that death occurred as a result of _____ from the causes and on the date stated above.									
23a. SIGNATURE D. C. O'Neil			23b. ADDRESS 4523 S. Kingsley			23c. DATE SIGNED 10/10/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-13-55		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
DATE REC'D BY LOCAL REG. OCT 11 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.				

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

Hours 12-2 PM

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. *None* working under my personal supervision..

Student *None* _____
Signature of Student Embalmer

Signed *Delia J. Krupar* _____

Licensed Embalmer No. *349*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.