FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40227

FILED DEC 6 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10931

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Deaconess Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days) 83 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town (If outside city or town limits, write "RURAL") 17
(d) Street No. 1911 Sullivan Ave. (If rural, give location) 9 26 10
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Katherine Stodieck
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased February (Month) 14th (Day) 1864 (Year)

8. AGE: Years 83 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Charles Stodieck
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Katherine W. Fahlenkamp
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Martha W. Hengelsbeig
(b) Address 4236 Neosho St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Johns Cemetery
18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.
19. (a) NOV 30 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28th year 1947 hour 8:15 Pm. minute M.

21. I hereby certify that I attended the deceased from Nov. 22, 1947 to Nov. 28, 1947 that I last saw her alive on Nov. 28, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Auricular fibrillation	2 wks
Due to: Arteriosclerotic heart disease	5 years
Due to: Cerebral softening	0 years
Other conditions (Include pregnancy within 3 months of death): Leukemia	

Major findings:
Of operations 93
Of autopsy

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address 12 E. Lockwood Date signed 11/29/47

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

Jefferson City Printing Co.

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed. John C. Buckholz

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis Av

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.

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3-45
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 314 Primary Registration District No. 1803 Registrar's No. 1093

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Katherine Stodeck

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Oct. 14 86
(Month) (Day) (Year)

8. AGE: Years 83 Months Days If less than one day hr. min.

9. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. F. Broderick (Registrar's signature)
DEC

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 1949 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

40227