

Registration District No. 7911

Primary Registration District No. 1003

Registrar's No. 3313

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:
4034 North Market St
(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)

3. (a) PRINT FULL NAME William H Abstein 123

3. (b) If veteran, name war None 3. (c) Social Security No. 493-03-6857

4. Sex Male 5. Color or race White 6. (c) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Helen Abstein 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased February 2 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 2 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Assembler

11. Industry or business Wagner Electric Co

MOTHER FATHER { 12. Name Karl Abstein Germany

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

MOTHER FATHER { 14. Maiden name Dorothy Straub Missouri

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

16. (a) Informant's own signature Helen Abstein
 (b) Address 4034 North Market St

17. (a) Burial (b) Date thereof April 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Reiderwieden Funl Home
 (b) Address 1936 St Louis Ave

19. (a) APR 11 1940 (b) J. P. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis 11
(If outside city or town limits, write "RURAL")
 (d) Street No. 4034 North Market St
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
 year 1940 hour 1:30 P M minute _____ M.

21. I hereby certify that I attended the deceased from 2-9-40
 _____, 19____, to 4-8-40, 19____;
 that I last saw him alive on 4-7-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Paralyzing myocardial infarction
Raynaud's disease
cause unknown 1 yr.
 Due to _____
 Due to _____

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations 985
 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? _____

23. Signature [Signature] (M. D. or other) _____
 Address 8147 S. Jefferson Date signed 4-9-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.