

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32695

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis mo** (d) Street No. **2609 So Grand Blvd.** Registered No. **8749**
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **2609 So. Grand Blvd** St. **17**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Mar**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **August Lambrecht**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 6, 1856**
7. AGE YEARS **81** MONTHS **6** DAYS **12** If LESS than 1 day, hrs. or min.
OCCUPATION **Housewife**
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **Cincinnati**
(STATE OR COUNTRY) **Ohio**

FATHER 13. NAME **Unknown**
14. BIRTHPLACE (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Unknown**
16. BIRTHPLACE (CITY OR TOWN) **"**
(STATE OR COUNTRY)

17. INFORMANT **Mrs. H. H. Helbing**
(ADDRESS) **4963 Fountain Ave**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **St. Matthews** DATE **Sept 20** 1937

19. FUNERAL DIRECTOR **Chas. A. Bull**
(ADDRESS) **4451 Washington Bl.**

20. FILE **SEP 19 1937** **J. Biedeck**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 18, 1937**

22. I HEREBY CERTIFY, That I attended deceased from **May** 1937 to **Sept 18** 1937

I last saw her alive on **Sept 17** 1937. Death is said to have occurred on the date stated above, at **9 A.** m.

The principal cause of death and related causes of importance were as follows:

Arteriosclerotic lateral sclerosis, Bulbar type

Date of onset

Other contributory causes of importance:

Name of operation **None** Date of
What test confirmed diagnosis? **clinical** Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify
(Signed) **Edward Helbing**, M. D.
(Address) **4963 Fountain**

STATEMENT BY LICENSED EMBALMER

I, John Ketter

Licensed Embalmer No. 3380

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

 L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

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.)