

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6697**

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Lutheran Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 Days
 In this community 14 Years (Specify whether years, months or days)

RECD SEP 14 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town St. Louis 23
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2131 S. 4th St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
 year 1939 hour 6 minute 50 a.m.

21. I hereby certify that I attended the deceased from Febr. 23, 1939, to July 30, 1939,
 that I last saw her alive on July 29th, 1939,
 and that death occurred on the date and hour stated above.

Immediate cause of death Toxic Toxicoses & Thyroid Crisis
 Due to degenerative Adenomatous Thyroid
 Duration 5 Mos.

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Large Adenomatous Tox. Gastric
 Of operations None
 Of autopsy None

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Henry P. Traul M.D.
 Address 2905 Cherokee St. Date signed 7/31/39

3. (a) PRINT FULL NAME Marie Gabriel
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Nick
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 8 1875
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>1</u>	<u>22</u>	hr. _____ min.

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

10. Usual occupation Home

11. Industry or business ?

12. Name Gregori

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Paul J. Hauber

(b) Address 2131 S. 4th St.

17. (a) Burial (Burial, cremation, or removal) N. S. S. Peter & Paul
 (b) Date thereof 8/2/39
 (Month) (Day) (Year)

(c) Place: burial or cremation N. S. S. Peter & Paul

18. (a) Signature of funeral director Wacker - Keldent
 (b) Address 2331 S. Broadway

19. (a) AUG 1 1939 (b) J. B. Bricker
 (Date received local registrar) (Registrar's signature)

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.

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..... *Frank J. Wyland Jr.*

Licensed Embalmer No..... *2645*

P. O. Address..... *St Louis Mo*

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, above space should be left blank.