

Registration District No. 791

Primary Registration District No. 1000

1. PLACE OF DEATH: **FILED FEB 17 1940**  
(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: 4442 Olive 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 50 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 19  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4442 Olive St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Louisa Fehlhhammer  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 27  
year 1940 hour 9 minute 20 PM

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Otto Fehlhhammer 6. (c) Age of husband or wife If alive \_\_\_\_\_ years  
7. Birth date of deceased September 16, 1862  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 17<sup>th</sup> 1940 to Jan 27 1940  
that I last saw her alive on Jan 21 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 4 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Hypertensive Heart Disease  
Calcification of Breast  
Due to Arterial Sclerosis  
Due to Arterial Sclerosis

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

Other conditions Arteriosclerotic Hemiparesis  
(Include pregnancy within 3 months of death)  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

10. Usual occupation Home  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name John Dietz  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaretha Feuerbacher  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Terese Fehlhhammer  
(b) Address 4442 Olive  
17. (a) Burial (b) Date thereof 1/30/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Matthews Cem.  
18. (a) Signature of funeral director Wasker-Weldner  
(b) Address 2331 S. Broadway  
19. (a) JAN 30 1940 (b) J. F. Brudick  
(Date received local registration) (Registrar's Signature)

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 Royal A. Hoffer (M. D. or other) \_\_\_\_\_  
Address 1703 So. Grand Date signed 1/27

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. McLeod Sr.*

Licensed Embalmer No. *2675*

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.**