

FILED AUG 5 1940

Registration District No. **784**
Primary Registration District No. **111**

Registrar's No. **1444**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 3511 Connecticut Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Margaret Ohligschlager

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1940 hour 2 minute 20 A.M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Peter Ohligschlager

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

7. Birth date of deceased Oct. 1, 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 19, 1940, to July 31, 1940
that I last saw h ER alive on 31st July, 1940
and that death occurred on the date and hour stated above

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>9</u>	<u>30</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage Duration. 12 days

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

Due to Hypertension

Due to 930

10. Usual occupation Housework

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

11. Industry or business at home

MOTHER

12. Name John Koher

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

Major findings: Of operations None

Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

14. Maiden name Don't know

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

16. (a) Informant Mrs. Anna Grau

(b) Address 3511 Connecticut

17. (a) Burial (b) Date thereof Aug. 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Weick Bros. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) Aug - 1 1940 (b) M. R. Meyer
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence _____

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

While at work? _____
(Specify type of place) (e) Means of injury

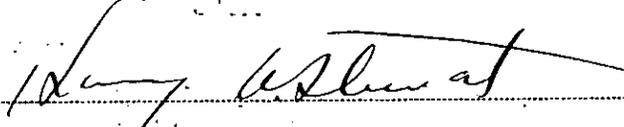
23. Signature Maurice A. Deier (M. D. or other) M.D.
Address 8924 St. Charles Rd Date signed 8/1/40
St. Louis County, Mo.

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



Licensed Embalmer No. **3722**

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.