

FILED SEP 25 1940

791

Registration District No. **1003**

Registrar's No. **7182**

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

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:
3659 Blow Street **2)**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether _____)
In this community 47 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Margaret Hornig **652**

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Louis Hornig 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased September 13, 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 11 Days 9 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Louis Schuchmann

18. Birthplace Germany **6**
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Schultz

15. Birthplace Germany **6**
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Hornig
(b) Address 3659 Blow Street

17. (a) Cremation (b) Date thereof Aug. 26, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Reideriseder funeral home

(b) Address 1936 St. Louis Avenue

19. (a) AUG 26 1940 (b) J. B. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis **1**
(If outside city or town limits, write "RURAL")
(d) Street No. 3659 Blow Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. 47 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd
year 1940 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb., 1940, to Aug 22, 1940,

that I last saw her alive on Aug 20, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of that ovary **1 yr.**

Due to 49

Due to _____

Other conditions General carcinomatosis **3 mo**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Karl Balazs (M. D. or other) **1**

Address 3627 Cleveland Date signed 8/24/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. K. J. Balaga
3623 Cleveland

2-3
7-8

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.....

Delis J. Krispin

Licensed Embalmer No.....

3497

P. O. Address.....

1936 St Louis

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.