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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40745**
Registrar's No. **8022**

791067

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution: **DePaul Hospital**
(d) Length of stay: In hospital or institution **2 weeks**
In this community **life**

3. (a) PRINT FULL NAME **Sarah E. Asche**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Gustave** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **November 24, 1876**

8. AGE: Years **63** Months **9** Days **29** If less than one day hr. _____ min. _____

9. Birthplace **Perry County Missouri**

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Burkhardt**
13. Birthplace **Perry County Missouri**
14. Maiden name **Schuessler**
15. Birthplace **Perry County Missouri**

16. (a) Informant **Edwin H. Asche**
(b) Address **3909a Fillmore**

17. (a) **burial** (b) Date thereof **9/26/40**
(c) Place: burial or cremation **Our Redeemer Cem.**

18. (a) Signature of funeral director **John S. Ziegenhain**
(b) Address **7027 Gravois**

19. **SEP 26 1940** (b) **J. P. Bradish**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **4372 Holly Hills**
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **23**
year **1940** hour **12:30** minute _____ P. M.

21. I hereby certify that I attended the deceased from **1935**
_____ 19 _____ 19 **40**
that I last saw her alive on **Sept 23** 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial failure Duration **3 days**
Gastric hemorrhage **2 wks**
Tuberculosis **5 yrs**

Other conditions _____
Major findings: Of operations **80**
Of autopsy _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature **Oliver Hill** (M. D. or other) _____
Address **4952 Maryland** Date signed **9-25-40**

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

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 E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Graves

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.