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DX23159

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **8623**

NOV 16 1940

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

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: 3225 No. Florissant Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Year 1 Month
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis. 20
(If outside city or town limits, write "RURAL")

(d) Street No. 3225 No. Florissant Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Clara Koschmeider.

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18th.
year 1940 hour 7. minute 30 A.M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased October 16th. 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 20, 1940 to Oct. 18, 1940
that I last saw her alive on Oct. 17, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

62 0 2 hr. min.

Immediate cause of death Apoplexy (Apoplexy) 1 week
Duration

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation At Home.

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER {

12. Name Francis Koschmeider.

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

14. Maiden name Madeline Goetz.

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Sister Jeane.

(b) Address 3225 No. Florissant Ave.

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

(a) Accident, suicide, or homicide (specify) _____

17. (a) Burial (b) Date thereof 10-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place)

Means of injury _____

19. (a) _____ (b) J. F. Budick
(Registrar's signature)

23. Signature Arthur A. Prekonig (M. D. or other) M.D.
Address 1525 1/2 Cass Ave Date signed 10/18/40

1525-a
6-8-88
C. Marshall

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: *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address *3840 Russell*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.