

Registration District No.

Primary Registration District No.

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: Jewish 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)

8. (a) PRINT FULL NAME Thekla A. Herwig

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 Single

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

7. Birth date of deceased June 21, 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Saleslady

11. Industry or business Sonnenfelds

12. Name August F. Herwig

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

14. Maiden name Maria A. Krie

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

16. (a) Informant Roland F. Herwig
(b) Address 520 West Gate

17. (a) Burial (b) Date thereof 12/6/40
(Burial, cremation, or removal) Valhalla Cemetery
(Month) (Day) (Year)

(c) Place: burial or cremation Edith E. Ambruster

18. (a) Signature of funeral director Edith E. Ambruster
(b) Address 4234 Manchester

19. (a) DEC 5 1940 (b) J. H. Brecheek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town University City N.R.
(If outside city or town limits, write "RURAL")
(d) Street No. 520 West Gate
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 3.
year 1940 hour 4 pm minute _____ M.

21. I hereby certify that I attended the deceased from May 1940
_____ 19____ to 12/3/40 19____;
that I last saw her alive on 12/3/40 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Gangrene of small intestine caused by fibrous band, resulting across small intestine
Due to non-malignant
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy: above

Duration 4-5 days
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? _____
(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 L. M. Kotter (M. D. or other) _____
Address Jewish Hosp. St. Louis Date signed 12/4/40

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

MOTHER FATHER

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 *Harvey Eymck*.....

..... Licensed Embalmer No. 1284.....

..... 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.