

FILED JAN 8 1941  
Registration District No. 784

Primary Registration District No. 113

Registrar's No. 2471

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town UNIVERSITY CITY  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST. LOUIS  
(c) City or town UNIVERSITY CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7373 KINGSBURY  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

8. (a) PRINT FULL NAME MARY ULRICH  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month 12 day 29  
year 1940 hour 3:30 minute \_\_\_\_\_ A. M.

4. Sex 7 5. Color or race wh 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife George B. Ulrich 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 13 - 1846  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-25-40, 19\_\_\_\_, to 12-29-40, 19\_\_\_\_;  
that I last saw her alive on 12-29-40, 19\_\_\_\_, and that death occurred on the date and hour stated above.

8. AGE: Years 94 Months 2 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral apoplexy - Duration 24 hrs.

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

Due to arteriosclerosis  
arterio-cerebral thrombosis  
Due to senility

10. Usual occupation nil

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: 8 JA

11. Industry or business \_\_\_\_\_  
12. Name ? Hellman  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Bertha Falkman  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant's own signature Mrs. Elise Slagter  
(b) Address 7373 Kingsbury  
17. (a) Cremation (b) Date thereof 12-30-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Grove

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 X

18. (a) Signature of funeral director James J. Bopp, Inc.  
(b) Address 131 W. Argonne  
DET. 29 1040 (c) R. M. Newman  
(Date received local registrar) (Registrar's signature)

23. Signature R. M. Newman (M. D. or other) 1/2/41  
Address 27 20 Washington Date signed 1/2/41

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Duration 24 hrs.  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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.....

*Kenneth J. Boyap*

Licensed Embalmer No. *3042*

P. O. Address. *Clayton*

**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.**