

Registration District No. **784**

Primary Registration District No. **11**

Registrar's No. **1310**

1. PLACE OF DEATH:

(a) County **St. Louis,**
(b) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
New St. Mary's 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)

3. (a) PRINT FULL NAME **Teresa Hellmann**

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 **Married**

6. (b) Name of husband or wife **Peter** 6. (c) Age of husband or wife if alive **59 yrs** years

7. Birth date of deceased **May 6 1883**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	58	1	16	hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Michael Dudenhoeffer**

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

14. Maiden name **Pauline Gruber**

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

16. (a) Informant **Peter Hellmann**
(b) Address **3514a Missouri Ave.**

17. (a) **Burial** (b) Date thereof **June 25, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **SS. Peter & Paul Cem.**

18. (a) Signature of funeral director **J. H. Golden**
(b) Address **2842 Meramec St.**

19. (a) **JUN 23 1941** (b) **J. R. Meyer**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No. **3514a Missouri Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **15** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **22nd**
year **1941** hour **7** minute **25** A. M.

21. I hereby certify that I attended the deceased from **6-10**
19**41**, to **6-22** 19**41**
that I last saw h. ~~er~~ alive on **6-22** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary embolism
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy **Pulmonary embolism**

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 _____
Signature **J. R. Meyer** (M.D. or other) **0**
Address **4620 Olive St.** Date signed **6-23-41**

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

MOTHER FATHER

DEPT. OF HEALTH
ST. LOUIS, MO.

1110

MAY 27 1942

JAN 22 1953

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 *Lorion C. Percy*

Licensed Embalmer No. 4094

2842 Meramec St.
P. O. Address..... St. Louis, Mo.....

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.

20-41
K27852

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1310 4

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Rich. Hts.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Marys
 (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

3. (a) PRINT FULL NAME Teresa Holloman
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ year _____ month _____ day

7. Birth date of deceased (Month) (Day) (Year) _____
 8. AGE: Years 58 Months _____ Days _____ If less than one year _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country) _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-23-4 (b) TR [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country _____ (Yes or No)
 If yes, name country _____

20. DATE OF DEATH: Month June day 22-41
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Obstructive congestion & pneumonia & etc
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) 108

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 Grey Jones (M. D. or other) _____
 Address 420 [Address] Date signed [Date]

SUPPLEMENTARY

MOTHER FATHER

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

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

MAY 27 194

S-22745