

13-40  
7-39  
X23152

**FILED OCT 18 1941**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

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: **Deaconess 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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Gasconade** **37**

(c) City or town **Hermann** **N.R.**  
(If outside city or town limits, write "RURAL")

(d) Street No. **Rural**  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **1** years.

3. (a) PRINT FULL NAME **Martha Verona Oelschlaeger**

(b) If veteran, name war **No.**

(c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **16**  
year **1941** hour **7** minute **A** M.

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife **Single**

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

7. Birth date of deceased **Feb. 6 1909**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug 18** 19**41**, to **Sept 16** 19**41**, that I last saw her alive on **Sept 15** 19**41** and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>32</b>	<b>7</b>	<b>10</b>	hr. _____ min.

Immediate cause of death **Adiposic Thrombocytopenic Purpura**

Due to \_\_\_\_\_

Due to **2**

Other conditions (include pregnancy within 3 months of death) **150**

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

10. Usual occupation **House Work**

11. Industry or business \_\_\_\_\_

Major findings: Of operations **Splicing Sept 14/41**

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

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name **Fritz Oelschlaeger**

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

14. Maiden name **Mary Allemann**

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

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? \_\_\_\_\_

16. (a) Informant **Fritz Oelschlaeger**

(b) Address **Hermann, Mo.**

17. (a) **Removal** (b) Date thereof **9/17/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hermann, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **SEP 17 1941** (b) **J. Buech**  
(Date received local registrar) (Registrar's signature)

23. Signature **J. Buech** (M. D. or other) \_\_\_\_\_  
Address **203 Brownwood** Date signed **9/17/41**

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

1920

**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 J. Wm. Binkley  
Licensed Embalmer No. 3653  
P. O. Address H. Lewis, Inc.

**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, fact should be so stated above.**