

2 2
4-41
7-39
X26390

Registration District No. 791

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:
St. Anthony's Hospital D
(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 35
(c) City or town Wilhelmina (If outside city or town limits, write "RURAL") N-R 3
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Aurelia Riehemann

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased SEPT. 29 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 0 1 hr. min.

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

10. Usual occupation HOUSEWORK

11. Industry or business _____

MOTHER FATHER { 12. Name Nickolas Femoyer

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

14. Maiden name Philomine Dietrich

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

16. (a) Informant B. FEMOYER

(b) Address CAMPBELL, Mo.

17. (a) Removal (b) Date thereof 10-1-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Campbell, Mo.

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

(b) Address 4700 Washington Ave.

19. (a) 067 1 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1941 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 28 1941 to Sept 30 1941
that I last saw her alive on Sept 30 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Breast - Multiple 2 nod?
Metastasis from breast 1 day.

Due to _____
Due to _____

Other conditions 5-5
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 5-5

Duration

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 1

23. Signature Robert S. Warren (M. D. or other) M.D.
Address 1115 Paul Brown Bldg Date signed Sept 16

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

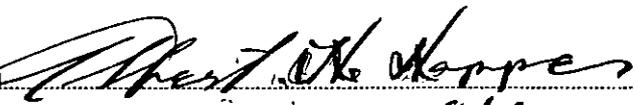
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No..... 1861

P. O. Address.....

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.