

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 33185  
Registrar's No. 8139Registration District No. 171Primary Registration District No. 1212 ✓

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Lutheran Hospital 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 Days  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Frank Remspecher3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. 490-12-45644. Sex Male 0 5. Color or  
race White 6. (a) Single, widowed, married, 3  
divorced Divorced6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased March 14 1914  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
27 6 28 hr. min.9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)10. Usual occupation Brewery Worker

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

MOTHER FATHER  
 { 12. Name Frank Remspecher  
 18. Birthplace St. Louis Mo. 0  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Burke  
 15. Birthplace St. Louis Mo. 0  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Cornelia Remspecher  
(b) Address 2715 A Indiana Ave.17. (a) Burial (b) Date thereof 10-15-41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sunset Burial Pk.18. (a) Signature of funeral director H. Schumacher  
(b) Address 3013 Meramec St.19. (a) OCT 13 1941 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2715 A Indiana Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? 22 years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 12th  
year 1941 hour 11 minute 30 A. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

*Autonomous Cerebral Cardiac  
 Hypertrophy, other  
 Anesthesia following  
 Removal of the Appendix and  
 Neckless diverticulum  
 at Lutheran Hospital  
 10/12/41 Exact time unknown*

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations 3:30Of autopsy 12:30

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically

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)  
(a) Means of injury \_\_\_\_\_23. Signature Thomas F. Callan (M. D. or other) 3  
Address Deputy Coroner Date signed 10/13/41

11-11-58

STATE OF TEXAS

DEPT. OF HEALTH

EMBALMERS

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

*Clarence Kochou*

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*Clarence Kochou*

Licensed Embalmer No. *3093*

P. O. Address *Bo 13 Meramec*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33185  
Registrar's No. 7

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County..... St Louis
- (b) City or town..... St Louis  
(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 years, months or days)

3. (a) PRINT FULL NAME Frank Rempischer

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased..... Mar 14, 1914  
(Month) (Day) (Year)

8. AGE: Years 27 Months 6 Days 27 (If less than one day) min.

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

10. Usual occupation.....

11. Industry of business.....

12. Name.....

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

14. Maiden name.....

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. DEC 2 1941 (b) J. F. Brudack  
(Date received by 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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 Day 1 Year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

1941  
S-33185