

ED SEP 11 1943 318
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **Saint Louis, Missouri.**
(c) Name of hospital or institution:
Alexian Bros. 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 **John Himmert**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married. **Divorced. Widowed.**

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

7. Birth date of deceased **October 20th, 1865.**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	10	11	hr. min.

9. Birthplace **Unknown, Germany 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Custodian Public School.**

11. Industry or business _____

MOTHER FATHER { 12. Name **? Himmert**
13. Birthplace **Unknown, Germany 4**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown, Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **George Himmert**
(b) Address **3839A California Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Sept. 2-1943.**
(Month) (Day) (Year)

(c) Place: burial or cremation **Zions Cemetery**

18. (a) Signature of funeral director **Ziegenfuss Bros.**
(b) Address **6409 Gravois Ave.**

19. (a) **AUG 31 1943** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County _____
(c) City or town **Saint Louis, 249**
(If outside city or town limits, write "RURAL")
(d) Street No. **3839 California Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **31st.**
year **1943.** hour **5** minute **0** A. M.

21. I hereby certify that I attended the deceased from **Aug 1st/43**
to **Aug 31st/43**
that I last saw him alive on **Aug 31st/43**
and that death occurred on the date and hour stated above.

Immediate cause of death **137**
Uremia

Due to **Hypertrophy of prostate gland**
Due to **Senility**

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

Major findings: _____
Of operations _____
Of autopsy _____

Duration **30 days**
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 **Leop A.P. Stein** (M. D. or other)
Address **2800A Chipwood** Date signed **8-31-43**

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..... *V. E. Morris*

Licensed Embalmer No. *9860*

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.