

FILED JAN 4 1944

1003

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **11566**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Lutheran Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether \_\_\_\_\_)

In this community Life.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3642 Fillmore St  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Louise Adkins

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20th  
year 1943 hour \_\_\_\_\_ minute 05 P. M.

21. I hereby certify that I attended the deceased from December 17, 1943 to December 20, 1943  
that I last saw her alive on December 20, 1943  
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife James

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased October 23rd, 1896  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Intra-cranial Pressure 1 mo.

Due to Brain tumor years  
Floor of 3rd. Ventricle

Due to malignant

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

47 1 27 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At home

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

MOTHER FATHER { 12. Name Chas. Duwe

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Augusta Fehse

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Brain tumor, compression of Pituitary; atrophy Thyroid, ovaries

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

16. (a) Informant James W. Adkins

(b) Address 3642 Fillmore Ave.

17. (a) Entombment \_\_\_\_\_ (b) Date thereof 12/23/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Mausoleum

18. (a) Signature of funeral director John J. Ziegenhagen & Sons

(b) Address 7207 Gravois

19. (a) DEC 23 1943 (b) J. J. Budeck  
(Date received local registrar) (Registrar's signature)

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 Burleigh Street (M. D. or other) M.D.  
Address 6006 Virginia Ave Date signed 12/24/43

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..... *E. P. Kidwell*.....  
..... Licensed Embalmer No. *3877*.....  
..... P. O. Address *7027 Gravois*.....

**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.**