

FILED JAN 4 1948

State File No. \_\_\_\_\_  
Registrar's No. 11826

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:  
Lutheran Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day  
(Specify whether years, months or days)

In this community 2 Months  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
17

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

(d) Street No. 5337 Robert Avenue  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Rev. William Miehe

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

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

6. (b) Name of husband or wife Mrs. Evelyn Miehe 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased August 16, 1905  
(Month) (Day) (Year)

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

38	4	9	_____ hr. _____ min.
----	---	---	----------------------

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

10. Usual occupation Pastor

11. Industry or business Ministry

MOTHER FATHER {

12. Name William Miehe

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

14. Maiden name Dorothea Hagemann

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

16. (a) Informant Mrs. Evelyn Miehe  
(b) Address 5337 Robert Avenue

17. (a) Burial (b) Date thereof Dec. 29, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Our Redeemer Cemetery

18. (a) Signature of funeral director Beiderwieden F.H. Inc.  
(b) Address 1936 St. Louis

19. (a) DEC 29 1948 (b) J. J. Budick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 25th  
year 1943 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from NOV. 18, 1943  
19. to DEC. 24, 1943  
that I last saw him alive on DEC. 24, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE Duration \_\_\_\_\_

Due to CHRONIC NEPHRITIS / 3 years

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

Other conditions 1943  
(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 H. E. Burkmann (M.D.)  
Address 3530 Grandview Ave. St. Louis Date signed Dec. 27, 1948

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

40276  
22430

Dr. H. E. Bachmann  
3530 Prairie  
9-11

---

---

**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..... *Delis J. Krupin*.....

Licensed Embalmer No..... *3497*.....

P. O. Address..... *1936 St. Louis Ave*.....

**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.**