

FILED MAR 13 1944 318

Registration District No. Primary Registration District No.

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

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: Beacon 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

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County 17  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3648 Bowen St  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LILA SOMMERHOLDER  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month March day 4  
 year 1944 hour 7 minute P M.  
 21. I hereby certify that I attended the deceased from Mar. 7 1944 to Mar 4 1944  
 that I last saw her alive on Mar 4 1944  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Caucasian  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Arthur Sommerholder 6. (c) Age of husband or wife if alive 44 years  
 7. Birth date of deceased Sept. 1901  
(Month) (Day) (Year)

Immediate cause of death PNEUMONIA ASTHMA  
 Duration 2 yrs.

8. AGE: Years 42 Months 5 Days 14  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to 1/2  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace Windsor Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

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

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name August Schaefer  
 13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Barbara Johnson  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Sommerholder  
 (b) Address 3648 Bowen St.  
 17. (a) Burial (b) Date thereof 3-7-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Sweet Burial Park

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? \_\_\_\_\_

18. (a) Signature of funeral director W. J. Schaefer, Mortician  
 (b) Address 4228 So. Kingshighway Blvd  
 19. (a) MAR 6 1944 (b) J. J. Ordeck  
(Date received local registrar) (Registrar's signature)

23. Signature J. J. Ordeck (M. D. or other) M.D.  
 Address 5930 Southwest Ave Date signed 3-6-44

*Mr Cleveland  
5930 South Street*

**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 *Edwin A. Mc Dermott*

Licensed Embalmer No. *3024*

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.**