

FILED MAR 20 1944 18

Registration District No.

Primary Registration District No.

2325

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:
St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3944 Shaw Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

AUGUST MAYER

3. (b) If veteran, name war _____

3. (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 Ottilie Mayer 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: August 29, 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 8 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Butcher

11. Industry or business

MOTHER FATHER { 12. Name Jacob Mayer
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Barbara Waller
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ottilie Mayer

(b) Address 3944 Shaw Ave.

17. (a) Cremation (b) Date thereof 3/11/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand Bl

19. (a) MAR 9 1944 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th
year 1944 hour 3:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Feb. 12th
19 44 to March 7th 19 44
that I last saw him alive on March 7th 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Acute ulcerative Bacterial endocarditis 5 days

Due to Cytoplasmic 5 days

Due to Carcinoma of Prostate 5+

Other conditions: 51
(Include pregnancy within 3 months of death)

Major findings: 51
Of operations: Prostatic Carcinoma

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) None

(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? 0 (Specify type of place) (b) Means of injury 0

23. Signature: J. H. Thomas (M.D. or other) _____
Address: 115 Lafayette Date signed: _____

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 Waring A. Stewart

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

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.