

FILED MAY 9 1944 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 St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One day
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State St. Louis (b) County 17

(c) City or town Missouri 9-3
(If outside city or town limits, write "RURAL")

(d) Street No. 6424 Arsenal Str
(If rural, give location)

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

3. (a) PRINT FULL NAME Pauline Hansen

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

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

6. (b) Name of husband or wife William Hansen 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Nov. 11, 1887
(Month) (Day) (Year)

8. AGE: Years 56 Months 5 Days 16 If less than one day
hr. min.

9. Birthplace Ashby, Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Adam Baker

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

{ 14. Maiden name Pauline Metz (State or foreign country)

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

16. (a) Informant William Hansen

(b) Address 6424 Arsenal, Str.

17. (a) Burial (b) Date thereof May 1, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery Brosschwig Und. Co.

18. (a) Signature of funeral director 4746 West Florissant

(b) Address APR 28 1944

19. (a) (Date received local registrar) (b) J. F. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th
year 1944 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from April 25 1944, to April 27 1944,
that I last saw her alive on April 27 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Post-Defect Duration _____

Due to Acute Cholerae stercor. Calculous

Due to _____

Other conditions 126.
(Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none

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 Dean A. Montgomery (M. D. or other) MD
Address 4002 W. Florissant Date signed 4/28/44

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..... *W. Wilkinson*

Licensed Embalmer No. *3575*

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.