

FILED MAY 3 1944

Registration District No. _____

Primary Registration District No. 3070

1. PLACE OF DEATH:

(a) County ST LOUIS
 (b) City or town WEBSTER GROVES MO.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
424 GREELEY AVE.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 20 yrs
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS
 (c) City or town WEBSTER GROVES MO.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 424 GREELEY AVE.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME LYDIA CHARLOTTE JANSSEN

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife FRED A JANSSEN 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased OCT 3 1861
 (Month) (Day) (Year)

8. AGE: Years 82 Months 6 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace ST LOUIS MO
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER FATHER { 12. Name Frederick Blomberg
 13. Birthplace ST LOUIS MO
 (City, town, or county) (State or foreign country)
 14. Maiden name Lydia Martha Loeffler
 15. Birthplace UNKNOWN GERMANY
 (City, town, or county) (State or foreign country)

16. (a) Informant Martha Pritchard
 (b) Address 420 Greeley Webster Groves Mo.

17. (a) INTERMENT (b) Date thereof APR-24-1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hallschlag Mausoleum

18. (a) Signature of funeral director Parker Und. Co.

(b) Address Webster Groves Mo.

19. (a) APR 26 1944 (b) E. G. Mc Gowan, M.D.
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
 year 1944 hour 4 minute 0 A.M.

21. I hereby certify that I attended the deceased from years _____, 19____, to _____, 19____;
 that I last saw her alive on 4/20/44, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis with nephritis & oedema Duration mos

Due to _____

Due to _____

Other conditions Semibity
 (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) 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? _____ (Specify type of place) (e) Means of injury _____

23. Signature James P. Baum M.D. (M. D. or other)

Address 13th N. Gore, Webster Groves Mo. Date signed 4/22/44

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.....

Leslie Welch

Registered Apprentice No.....

362

working under my personal supervision.

Signed.....

e. e. aldrich

Licensed Embalmer No.....

1382

P. O. Address.....

Delster Grove

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 978

Registration District No. 317 Primary Registration District No. 3070

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Lyle G. Janson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 3 1861
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>6</u>	<u>18</u>	<u>mo</u>

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 2
Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I last saw him _____ at _____ on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate Cause of Death arterio-sclerosis with nephritis & oedema

Due to Chronic nephritis c oedema

Due to Arterio-sclerotic degen. associated with senility

Other conditions _____
(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 Frank P. Samy M.D. (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY 2

SEP 22 1944

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