

FILED SEP 30 1944

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County Saint Louis, Missouri
(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Park Lane 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 Missouri (b) County Madison
(c) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 4921-A Finkman Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20th.
year 1944. hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from July 10, 1944 to Sept 20, 1944
that I last saw her alive on Sept 19, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Organic Valvular Heart Disease Duration 6 mo

Due to _____
Due to _____

Other conditions: Bronchitis 1 mo
(Include pregnancy within 5 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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature: J. M. Shaw (M. D. or other)
Address 2330 Union Date signed 9/22/44

3. (a) PRINT FULL NAME Bertha Glaessner
3. (b) If veteran, name war _____ 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 August Glaessner 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 4th, 1854
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>10</u>	<u>16</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER } 12. Name ? Milentz
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Bredie Stinger
(b) Address 4921-A Finkman Ave.

17. (a) Burial (b) Date thereof Sept. 23, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Mausoleum

18. (a) Signature of funeral director Siegenheim Bros.
(b) Address 6409 Gravois Ave.

19. (a) SEP 22 1944 (b) J. Bredes
(Date received local registrar) (Registrar's signature)

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..... *Homer W. Dritz*

Licensed Embalmer No. *3882*

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.