

FILED SEP 18 1944  
Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 7798

1. PLACE OF DEATH:

(a) County.....

(b) City or town ST. LOUIS 190  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
ST. JOHNS HOSP  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 WEEK  
(Specify whether)

In this community 50 YRS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MAJ

(c) City or town ST. LOUIS 1317  
(If outside city or town limits, write "RURAL")

(d) Street No. 4966 ODELL AVE  
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country N

3. (a) PRINT FULL NAME RACHEL M. WINERS

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife JOSEPH O | 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased JULY 19 1868  
(Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 18 If less than one day hr. min.

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

10. Usual occupation HOUSEWORK

11. Industry or business AT HOME

12. Name Aloysius Grohnart

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

14. Maiden name UNKNOWN

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

16. (a) Informant CAPT FRED WINERS

(b) Address 4966 ODELL AVE

17. (a) BURIAL (b) Date thereof 9 11 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW ST. PETER PAUL

18. (a) Signature of funeral director KRIEGER HAUSER

(b) Address 422 BASO. KING'S HIGHWAY

19. (a) SEP 10 1944 (b) J. Bebeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 7  
year 1944 hour 8 minute 0 P.M.

21. I hereby certify that I attended the deceased from Aug 31 1944  
1944, to Sept 7 1944  
that I last saw him alive on Sept 7 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute cholecystitis with perforation

Due to Cholelithiasis

Due to 1 26

Other conditions (Include pregnancy within 3 months of death)

Duration 7 days

Major findings: Of operations Cholelithiasis - Peritonitis due to bile from perforated gall bladder

Of autopsy Cholelithiasis - Peritonitis due to bile from perforated gall bladder

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) (c) Means of injury 0

23. Signature Augustus P. Munsch (M. D. or other) .....

Address 306 Humboldt Bldg Date signed .....

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

MOTHER FATHER

Mr. Muench  
Funeral Home

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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 Dick Stoverson

Licensed Embalmer No. 4007

P. O. Address Admission

**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.