

**FILED SEP 30 1944**  
Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis County**  
(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Bellefontaine Nursing Home**  
(If not in hospital or institution, write street number or location) **4**  
(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 **000**  
(c) City or town **St. Louis** **17**  
(If outside city or town limits, write "RURAL") **9**  
(d) Street No. **5019 Durant**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country **1**

3. (a) PRINT FULL NAME **Peter Naumann**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Mary Naumann** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **October 29 1858**  
(Month) (Day) (Year)

8. AGE: Years **87** Months **10** Days **19** If less than one day hr. \_\_\_\_\_ min.

9. Birthplace **Maxwell Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Iron Worker (Retired)**

11. Industry or business

12. Name **Frank Naumann**  
13. Birthplace **Unknown Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Billert**  
15. Birthplace **Unknown Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. James Burke**  
(b) Address **5019 Durant**  
17. (a) **burial** (b) Date thereof **9-21-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc.**  
**4700 Washington Blvd.**  
(b) Address  
19. (a) **SEP 25 1944** (b) **C. D. McPherson, M.D.**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **18**  
year **1944** hour **11:45** minute **A** M.

21. I hereby certify that I attended the deceased from **Sept. 18 1944** to **Sept 18 1944**  
that I last saw her alive on **Sept 18 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death **embolic aneurysm** Duration  
**chronic myocardial**

Due to **chronic myocardial**  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations **93d**  
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 **William R. W. W.** (M. D. or other)  
Address **1918 East Grand** Date signed \_\_\_\_\_

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

96000

**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.....

Licensed Embalmer No.....

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.**