

No. 2  
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-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JAN 15 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 39208  
Registrar's No. 11264

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Lutheran Altenheim - Halleberry  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 year (Specify whether  
 In this community 5 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Lutheran Altenheim 8721  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs Marie Bruer  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased June 29 1857  
(Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days 1 If less than one day 1 hr. 0 min.

9: Birthplace St Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
 12. Name Charles Luehrmann  
 13. Birthplace (Unknown)  
(City, town, or county) (State or foreign country)  
 14. Maiden name Louise kurz  
 15. Birthplace (Unknown)  
(City, town, or county) (State or foreign country)

16. (a) Informant Margt Spencer Supt Luth Altenheim  
 (b) Address 8721 Halls Ferry Road

17. (a) Burial (b) Date thereof Jan 2 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Beiderwieden F H, Inc  
 (b) Address 1936 St Louis Avenue

19. (a) JAN 1 1945 J. J. Bredner  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30  
 year 1944 hour 12: Noon minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from Sept 1943 to December 30 1944  
 that I last saw her alive on December 29 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis 5 yrs?  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions 930  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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 a work? \_\_\_\_\_ Means of injury \_\_\_\_\_  
 23. Signature Engene L Arnold (M. D. or other) MD.  
 Address 1449 W. Loran Date signed 12/30/44

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3737

P. O. Address 1926 St. Louis Ave

**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.**

Registration District No. *3, 8*

Primary Registration District No. *1003*

Registrar's No. *11264*

1. PLACE OF DEATH:

(a) County *St. Louis*  
 (b) City or town *St. Louis*  
(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 years, months or days)

In this community.....  
years, months or days

3. (a) PRINT FULL NAME *Marie Gruer*

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

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

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

7. Birth date of deceased *June 29 1905*  
(Month) (Day) (Year)

8. AGE: Years *87* Months *6* Days *1* If less than one day, min.

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

10. Usual occupation.....

11. Industry or business.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *JAN 19 1945* (b) *J. F. Braddock*  
(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 *Dec* day *30*  
 year *1945* hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings:  
 Of operations.....

PHYSICIAN

Of autopsy.....

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

39208