

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

FILED JAN 5 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

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:
2920 Bailey 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 19 years (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Mrs Anna Hellwege

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 M

6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased August 24 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69	3	28	hr. min.
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9. Birthplace Frohna Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Gottfried Schuessler

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

14. Maiden name UNKNOWN

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

16. (a) Informant John Hellwege (Husband)

(b) Address 2920 Bailey Ave

17. (a) Burial (b) Date thereof Dec 26 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frohna, Missouri

18. (a) Signature of funeral director Beiderwieden F H, Inc

(b) Address 1936 St. Louis Avenue

19. (a) DEC 23 1944 (b) J. F. Greedek
(Date received local registrar) (Registrar's signature)

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. 2920 Bailey 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 Dec day 22
year 1944 hour 2 minute 10 A. M.

21. I hereby certify that I attended the deceased from December 12, 1944 to Dec. 22nd 1944
that I last saw h alive on Dec. 21st 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia

Due (Cerebral Haemorrhage) (non traumatic) 10 days

Due to arterial sclerosis 3 years

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 Arthur Theo. Vogel (M. D. or other) _____
Address 4244 W. Florissant Date signed 12/22/44

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. *3497*

P. O. Address. *1936 St. Louis*

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.