

FILED JAN 15 1945
Registration District No. **348**

Primary Registration District No. **1003**

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

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:
Christian 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)

3. (a) PRINT FULL NAME **Cora Alice Oppenlander**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Wh.** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **unknown**
(Month) (Day) (Year)

8. AGE: Years **about 79** Months **--** Days **--** If less than one day hr. min.

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

10. Usual occupation **Nurse lady**

11. Industry or business **Famous-Barr Co.**

12. Name **Christian Oppenlander**

13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Alice Witham**

15. Birthplace **Cincinnati Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Charles Austin**

(b) Address **6275 Enright Ave.**

17. (a) **Burial** (b) Date thereof **12-30-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cem.**

18. (a) Signature of funeral director **Heerman Rindskopf**

(b) Address **5216 Delmar Blvd.**

19. (a) **DEC 29 1944** (b) **[Signature]**
(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. **6433a Wade Ave.**
(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 **29**
year **1944** hour **6** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Dec 27** 1944 to **Dec 29** 1944
that I last saw her alive on **Dec 29** and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia**

Duration **4 days**

Due to _____

Due to **74**

Other conditions (Include pregnancy within 3 months of death) **Lymphatic Leukemia**

Major findings: **Lymphatic Leukemia**

Of operations _____

Of autopsy **Lobar Pneumonia**

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 **Geo. A. Miller** (M. D. or other) _____

Address **2739 N. Grand** Date signed **12-29**

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. 4029

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.