

FILED FEB 7 1945

1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **856**

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:
City Sanitarium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 1/2 yrs. 5 mos. 24 d.
(Specify whether
 In this community 44 yrs.
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. 3316 Algon Ave
City Sanitarium
 (e) Citizen of foreign country? Yes (Yes or No)
 If yes, name country Germany

3. (a) PRINT FULL NAME CHARLOTTE LIPKA

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced Div.
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased January 8th 1867
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>78</u> | <u>0</u> | <u>19</u> | _____ hr. _____ min. |

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Chris Mousker 4
 13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
 14. Maiden name Marie Gerouske
 15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant J. Singler
 (b) Address 5400 Arsenal St.

17. (a) Burial (b) Date thereof Jan 30/45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation See Burial Form

18. (a) Signature of funeral director Thos. Curtis & Son
 (b) Address 2906 Gravois Ave

19. (a) JAN 28 1945 (Date received local registrar)
J. Z. Bredel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 27
 year 1945 hour 6.40 minute A M.

21. I hereby certify that I attended the deceased from Feb. 1st, 1943, to Jan. 27, 1945
 that I last saw her alive on Jan 27, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to Carcinoma of the Stomach 1 yr.

Due to Broncho Pneumonia 3 days

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)
 (1) (2) Means of injury _____
 Signature C. J. McConnell (M. D. or other)
 Address 5400 Arsenal St. St. Louis Date signed 1/27/45

WHILE FLAINLY—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..... *David Van Fossen*

Licensed Embalmer No. *4242*

P. O. Address..... *2906 Gravois*

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.