

FILED JAN 25 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 292

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: LUTHERAN 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 CLARA MORTIMER

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife WILLIAM MORTIMER 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 20 1863
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace ST. LOUIS MO. U.
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

11. Industry or business _____

MOTHER FATHER { 12. Name HENRY KOEHN
13. Birthplace GERMANY U
(City, town, or county) (State or foreign country)
14. Maiden name ALVINA ?
15. Birthplace unknown - 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Louis Kielsmeier

(b) Address 5308. Murdoch

17. (a) CREMATION (b) Date thereof JAN. 11 / 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MISSOURI CREMATORY

18. (a) Signature of funeral director E. J. Schurr

(b) Address 3125 LAFAYETTE AV

19. (a) JAN 20 1945 (b) Registrar's signature J. F. Brudick
(Date received local registrar) (Date)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County (22) COO
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1226 S. 18th St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country N

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9
year 1945 hour 6:30 minute _____ A.M.

21. I hereby certify that I attended the deceased from Dec 27 44
_____, 19____, to Jan 9, 19____
that I last saw her alive on Jan 8, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hem. Duration 12 days

Due to Pneumonia

Due to 82

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

Major findings: Of operations none
Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) PO

(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) _____
(c) Means of injury _____

23. Signature J. F. Brudick (M. D. or other) _____

Address 311 S. L. Street Date signed 1/9/45

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.....

Joseph B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address *St Louis Mo*

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. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(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
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Clara Matimer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr _____ 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 _____ (State or foreign country) _____
15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) _____ (Day) _____ (Year) _____
(Burial, cremation, or removal) Oak Grove Crem.
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 1-20-45 (b) J. F. Bredek
(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 1 day 9
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

595