

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

148

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:
5531 Eichelberger
(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 **Eva Cecelia Unger (nee Horn)**

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 **Widow**

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

7. Birth date of deceased **11 26 1877**
(Month) (Day) (Year)

8. AGE: Years **67** Months **1** Days **8** If less than one day hr. _____ min. _____

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

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER { 12. Name **Sebastian Horn**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Wunsch**
15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **George R. Spindler**
(b) Address **5531 Eichelberger**

17. (a) **Burial** (b) Date thereof **1-8-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Truth Center Mortuary**
(b) Address **4024 Lindell Blvd.**

19. (a) **JAN 8 1945** (Date received local register)
J. F. Bedeck (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. **5531 Eichelberger** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **4**
year **1945** hour **3:05 A.M.** minute _____ M. _____

21. I hereby certify that I attended the deceased from **March 10th 1944** to **Jan 4th 1945**
that I last saw her alive on **Jan 3rd 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Uraemic Coma 2 days
Chronic Nephritis 2 yrs.
Mitral Regurgitation of Heart 2 yrs.

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

Major findings:
Of operations _____
Of autopsy _____

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?

23. Signature **Albert Beisbarth** (M. D. or other) **MD.**
Address **3606 Gravois** Date signed **1-5-45**

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

2-43
7-39
X35697

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 *Howard P. Rowland*

Licensed Embalmer No. *3114*

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.