

FILED MAR 5 1945

Registration District No. *317*

Primary Registration District No. *3069*

Registrar's No. *569*

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Richmond Heights Townsp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Clayton (Clayton Townsp)  
(If outside city or town limits, write "RURAL")  
(d) Street No. LaDue & Lindbergh  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Ide Dauster

3. (b) If veteran,

name war None

3. (c) Social Security

No. None

4. Sex

F

5. Color or

race W

6. (a) Single, widowed, married,

divorced M

6. (b) Name of husband or wife

Martin A

6. (c) Age of husband or wife if

alive 69 years

7. Birth date of deceased

Feb 22 1870  
(Month) (Day) (Year)

8. AGE:

Years 73 Months 0 Days 4  
If less than one day  
hr. min.

9. Birthplace

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

10. Usual occupation

Housewife

11. Industry or business

12. Name

Unknown

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

Martin A. Dauster

(b) Address

Clayton, Mo. R#1

17. (a)

Burial  
(Burial, cremation, or removal)

(b) Date thereof

2-28-45  
(Month) (Day) (Year)

(c) Place: burial or cremation

St. Pauls Ev. Cemetery

18. (a) Signature of funeral director

Blumans Brodner

(b) Address

2504 - Woodson Rd - Overland

19. (a)

MAR 1 1945  
(Date received local registrar)

Dr. E. J. McLean  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26  
year 1945 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from  
Feb 24 1945 to Feb 26 1945  
that I last saw her alive on Feb 25 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

8301

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

Raymond C. McLean (M. D. or other)  
Address Perkwood Mo Date signed 2-27-45

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

MOTHER FATHER

APR 2 1945

**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 Oscar J. Mueller  
Licensed Embalmer No. 3039  
P. O. Address Overland # 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.**