

FILED APR 6 1945

Primary Registration District No.

1003

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: Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 60 years
years, months or days)

3. (a) PRINT FULL NAME Catherine Hehl

3. (b) If veteran, name war. no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Henry 6. (c) Age of husband or wife if alive 1st. 1869
7. Birth date of deceased Dec. 1st. 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 14 If less than one day
hr. min.

9. Birthplace Madison Co. Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business

12. Name Adam J. Ottmann
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Eva Kern
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Eva Haeckel
(b) Address 5016 Idaho

17. (a) burial (b) Date thereof 3-19-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Dr. Schumacher
(b) Address 3013 Meramec

19. (a) MAR 16 1945 (b) I. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5016 Idaho
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15th.
year 1945 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from March 11, 1945, to March 15, 1945
that I last saw her alive on March 15, 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Uremia Duration 6 days

Due to Nephrosclerosis
Due to Generalized Arteriosclerosis

Other conditions Hypertension Hypertension
(Include pregnancy within 3 months of death)
heart disease Cardiac Decompensation

Major findings: Of operations
Of autopsy
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? (c) Means of injury
23. Signature David M. Shelling Jr. (M. D. or other) M.D.
Address 4500 Olive Street Date signed 3/16/45

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.....

Francis Williamson

Licensed Embalmer No.....

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.