S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8372

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2972

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: De Paul Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks (Specify whether years, months or days)

In this community 54 years

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. 4964 Tholozon
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country -----

3. (a) PRINT FULL NAME Miss Alice Westermann

3. (b) If veteran, name war -------

3. (c) Social Security No. -----

4. Sex Female 1

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife ---

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased August (Month) 7, (Day) 1890 (Year)

8. AGE: Years 54 Months 7 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, (City, town, or county) Missouri. 0 (State or foreign country)

10. Usual occupation At Home

11. Industry or business ----

FATHER 12. Name William H. Westermann

FATHER 13. Birthplace St. Louis, (City, town, or county) Missouri 0 (State or foreign country)

MOTHER 14. Maiden name Bertha Gockel

MOTHER 15. Birthplace St. Louis, (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Mr. Oscar Westermann

(b) Address 4963a Northland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/1945 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Beiderwieden F. H., Inc.

(b) Address 1936 St. Louis Avenue

19. (a) APR 3 1945 (Date received local registrar) (b) J. F. Bedrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 1 day March year 1945 hour 3 minute 05 P.M.

21. I hereby certify that I attended the deceased from March 1, 1945, to March 31, 1945, that I last saw her alive on March 31, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of ovaries	9 months
Due to: General abdominal metastasis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: March 1945 Carcinoma of ovaries - General abdominal Carcinomatosis	
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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature F. R. Finnegan (M. D. or other) M.D.

Address 539 N. Grand Date signed April 1/45

(Licensed Embalmer's Statement on Reverse Side)

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 Glen W. Hatz

Licensed Embalmer No. 3737

P. O. Address 1936 St. Louis Ave

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.