

S. No. 2
M-5-43
5-17-39
I X38871

FILED MAY 3 1945 8 18

Registration District No. _____ Primary Registration District No. **1003**

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

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:
3997 Dover Place
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 45 years
years, months or days

3. (a) PRINT FULL NAME Mrs. Amalia F. Oehlert

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 Widowed

6. (b) Name of husband or wife John G. Oehlert

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

7. Birth date of deceased October 3 1864
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	6	17	_____ hr. _____ min.

9. Birthplace Altenburg, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Dietrich

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Theresa Goecke

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jos. A. Ent

(b) Address 3997 Dover Place

17. (a) Burial (b) Date thereof 4/23/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Trinity Luth. Cem.

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

(b) Address 1936 St. Louis Avenue

19. (a) APR 23 1945 (b) J. F. Bredeck
(Date received local registrar) (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. 3997 Dover Place
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 20,
 year 1945 hour 2: minute 48 P. M.

21. I hereby certify that I attended the deceased from Mar 21-45
 _____, 1945 to April 20, 1945
 that I last saw her alive on April 20, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (apoplexy)

Due to Chronic myocarditis

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration 1 day

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)

(c) Means of injury _____

23. Signature M. W. Gansolis (M., D. or other)
 Address 3624 Arsenal St. Date signed 4/21/45

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Glen W. Hay

Licensed Embalmer No..... *3737*

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.