

FILED APR 27 1945
818

Primary Registration District No. 1003

Registrar's No. 3385

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days (Specify whether _____)
In this community Lydia Rabe Sanner.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Clayton
(If outside city or town limits, write "RURAL") 96 N.R.
(d) Street No. 901 Bemiston Ave.
(If rural, give location) 2
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME

Lydia Sanner

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 16th 1876
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1945 hour 9 minute 25 P.M.

21. I hereby certify that I attended the deceased from April 9, 1945, to April 14, 1945
that I last saw him alive on April 14, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) J.H.

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature F. R. Bradley (M. D. or other) _____
Address Barnes Hospital Date signed 4/15/45

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

MOTHER FATHER

10. Usual occupation At home
11. Industry or business _____
12. Name John H. Rabe.
13. Birthplace unknown Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Wilhelminia Strubbe.
15. Birthplace Cincinnati, Ohio 1
(City, town, or county) (State or foreign country)
16. (a) Informant Paul F. Plummer.
(b) Address 901 Bemiston Ave.
17. (a) Burial (b) Date thereof 4/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cemetery
18. (a) Signature of funeral director C.R. Lupton & Sons.
(b) Address 7233 Delmar Blvd.
19. (a) APR 17 1945 (Date received from Registrar)
J. F. Bredbeck (Registrar's signature)

Barnes Hospital

3385

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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 Bradford A. Miles
License/Embalmer No. 2901
P. O. Address University City

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.