

FILED JUN 4 1945

Registration District No. 377

Primary Registration District No. 3063

Registrar's No. 991

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton, mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis Co. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4-12-45 to 4-23-45  
(Specify whether years, months or days) 1.8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County St. Louis  
(c) City or town Pine Lawn, mo. (Pension) University  
(If outside city or town limits, write "RURAL") Clayton, mo. 6326  
(d) Street No. 3709 Manula  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CIARRA AHRENS

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, 2 divorced widow  
6. (b) Name of husband or wife Charles Ahrens 6. (c) Age of husband or wife if alive dec. years  
7. Birth date of deceased 2 3 80  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 2 20 hr. \_\_\_\_\_ min.

9. Birthplace Middle Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Thomas Phillips  
13. Birthplace Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Cassie Mollard  
15. Birthplace Middle Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Ahrens - patient

(b) Address 3709 Manula, Pine Lawn

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25/45  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cem.

18. (c) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) APR 24 1945 (b) E. E. Hanson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23  
year 1945 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4-12  
1945, to 4-23, 1945;  
that I last saw her alive on 4-23  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic  
Heart disease Duration \_\_\_\_\_

Due to 93 d

Due to \_\_\_\_\_

Other conditions Bleeding decubitus ulcer,  
(Include pregnancy within 3 months of death)  
Chromi's leucocoma, Paralysis agitans

Major findings: \_\_\_\_\_ PHYSICIAN \_\_\_\_\_  
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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature John J. Meagher (M. D. or other) M.D.

Address St. Louis Co. Hospital Date signed 4/23/45

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

**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..... *W. Wilkins*.....  
Licensed Embalmer No..... *3575*.....  
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.**