

S. No. 2  
DM-5-43  
v. 5-17-39  
X36671

**FILED JUN 19 1945**  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5000**

**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:  
City Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 33 day's  
(Specify whether years, months or days)

In this community                       
years, months or days)

**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. 1514 A Destrehan St.  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** Lillian B. Engeling

3. (b) If veteran, name war No

3. (c) Social Security No. No

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month June day 4th  
year 1945 hour 5 minute 15P M.

**21. I hereby certify that I attended the deceased from**                     , 19                     , to                     , 19                     ;

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph C. Engeling

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased June 30, 1888  
(Month) (Day) (Year)

that I last saw h                      alive on                     , 19                     ;

and that death occurred on the date and hour stated above.

Immediate cause of death Subdural hemorrhage of brain when they were in hospital operation with following hemiparesis of the extremities 14-1-1 Macleod's wound 11.50

due to                     

due to                     

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>11</u>	<u>4</u>	hr. <u>                    </u> min <u>                    </u>

Other conditions                       
(Include pregnancy within 3 months of death)

Major findings:  
Of operations                     

Of autopsy                     

**PHYSICIAN**  
                      
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Housework

11. Industry or business                     

**MOTHER FATHER**

12. Name Agustus Deaton

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

14. Maiden name Laura Roeder

15. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

**22. If death was due to external causes, file the following:**

(a) Accident, suicide, or homicide (specify) Unavoidable accident

(b) Date of occurrence June 5, 1945

(c) Where did injury occur?                       
(City or town) (County) (State)

(d) Did injury occur indoors about home, on farm, in industrial place, in public place?  
                      
(Specify type of place) (e) Means of injury                     

23. Signature                      (M.D. or other)  
Address                      Date signed 6-7-45

16. (a) Informant Joseph C. Engeling

(b) Address 1514A Destrehan St.

17. (a) Burial (b) Date thereof June 8, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director Paschedag-Henke Fun. Home

(b) Address 2825 N. Grand Blvd.

19. (a) JUN 6 1945 (Date received from registrar)  
J. F. Bredenk (Registrar's signature)

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.....

*John G. Growski*

Licensed Embalmer No. *3398*.....

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.**