

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **6814**

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: St. Anthony Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 hour  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 003  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6283 Odell Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Dona Marie Jehle

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 Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 2, 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
--- -- -- 1 hr. min.

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

10. Usual occupation None

11. Industry or business None

12. Name William C. Jehle

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

14. Maiden name Ruth Watkins

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

16. (a) Informant William C. Jehle

(b) Address 6283 Odell Ave.

17. (a) Burial (b) Date thereof 8/3/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old St. Peter & Paul Cem.

18. (a) Signature of funeral director Gebken-Benz

(b) Address 2842 Meramec Street.

19. (a) AUG 2 1945 J. F. Budeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2nd.  
year 1945 hour 2 minute -- A. M.

21. I hereby certify that I attended the deceased from 1 A.M. Sunday  
Aug 2, 1945, to 2 A.M. Sunday  
that I last saw him alive on Aug 2/45, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Apnea

Due to prematurity and abnormal presentation  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 159

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) (e) Means of injury \_\_\_\_\_

23. Signature William C. Jehle (M.D. or other) \_\_\_\_\_  
Address 534 North Grand Date signed 8/2/45

Dr. Wm. Stude. Humboldt Bldg. 2-4  
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.

*no embalming*

Signed..... *Robert Wheeler*

Licensed Embalmer No. *2178*

P. O. Address..... *St Louis Mo*

**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.**