

Registration District No. 318

Primary Registration District No. 1003

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:
4654 Ashland Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community years, months or days

3. (a) PRINT FULL NAME Elmer Drumtra
3. (b) If veteran, name war - - - - -
3. (c) Social Security No. 487-26-1714

4. Sex Male 0
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 November 30 1904
(Month) (Day) (Year)

8. AGE: Years 40 Months 8 Days 24
If less than one day hr. min.

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

10. Usual occupation Turret Operator

11. Industry or business

12. Name William Drumtra
13. Birthplace Germany 7
(State or foreign country)
14. Maiden name Sarah Beyer
15. Birthplace Altenburg Missouri /
(City, town, or county) (State or foreign country)

16. (a) Informant Otto Schmelzel
(b) Address 4601 Lexington Ave.

17. (a) Burial (b) Date thereof 8/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) AUG 27 1945 (b) J. F. Probst
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17 10
(If outside city or town limits, write "RURAL")
(d) Street No. 4601 Lexington Ave. 9
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24
year 1945 hour 7 minute 14 P. M.

21. I hereby certify that I attended the deceased from
....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death
Duration

Coronary Occlusion
Coronary Arteriosclerosis

Due to 94%

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.

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) (a) Means of injury

23. Signature of physician J. F. Probst (M. D. or other) 3
Address Date signed 8/27/45

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

MOTHER FATHER

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 *Ben E. Hoffman*

Licensed Embalmer No. *434*

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.