

FILED SEP 3 1945

Registration District No. _____ 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 **St. Anthony Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 weeks 2 days**
40 Years (Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis** **17 15**
(If outside city or town limits, write "RURAL")

(d) Street No. **3304 Meramec** **9**
(If rural, give location) **1**

(e) Citizen of foreign country? **no** **0** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Irma Caroline Van-Damme**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife **Gustave**

6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Oct. 6th 1891**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	53	10	13	hr. _____ min.

9. Birthplace **Belgium 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Work**

11. Industry or business _____

12. Name **Theo. Schallaert**

13. Birthplace **Belgium 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Belgium 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gus. Van-Damme**

(b) Address **3304 Meramec**

17. (a) **Burial** (b) Date thereof **8-23-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Park Lawn**

18. (a) Signature of funeral director **Jm Schumacher**
3013 Meramec

(b) Address _____

19. (a) **AUG 20 1945** (Date received local registrar)
J. F. Breda (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **Aug.** day **19**
year **1945** hour **10** minute **A.** M.

21. I hereby certify that I attended the deceased from **Feb 1 - 1945** to **Aug 18 1945**
that I last saw her alive on **Aug 18 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** **7**
Due to _____

Due to **93**
Other conditions **Hyper tension**
(Include pregnancy within 3 months of death)

Major findings: **No**
Of operations _____
Of autopsy _____

Duration _____

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? _____

(a) Signature **Joseph L. Lewis** (Specify type of place) (M. D. or other)

(b) Address **4065 So Grand** Date signed **8/20/45**

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

20
17
9

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.....

Francis Williamson

Licensed Embalmer No.....

3565

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.