S. No. 2
0M—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 3 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34742

State File No. 8

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 2516

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Marys Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Glendale 11
(If outside city or town limits, write "RURAL")

(d) Street No. 71 Frederick Lane 1
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME George D. Woehr

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Rose Woehr

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased April 12th, 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	6	12	hr. min.

9. Birthplace Koeltztown (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Sculpter

11. Industry or business Self Wood

FATHER
12. Name Joseph Woehr
13. Birthplace ..... (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Wilhelmenia Utrecht
15. Birthplace ..... (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Rose Woehr
(b) Address 71 Frederick Lane

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/45 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Peter & Pauls

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address 6633 Clayton Road

19. (a) 11-2-45 (Date received local registrar) (b) E G McGavan M D (Registrar's signature) M S

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30th, year 1945 hour 11 minute A M.

21. I hereby certify that I attended the deceased from Sept 28, 1945, to Oct. 30, 1945 that I last saw him alive on Oct. 30, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Decompensation	1 mo.
Due to Arteriosclerotic Heart Disease 97	
Due to	
Other conditions Pleural Effusion (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? ..... (Specify type of place)
While at work? ..... (e) Means of injury 0

23. Signature M. Ohmoto (M. D. or other) M.D.
Address St. Marys Hospital Date signed 10/30/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.