

FILED NOV 18 1945

1003

State File No. \_\_\_\_\_  
Registrar's No. 9610

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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. Louis City Hospital-Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 3107 A California  
(If rural, give location)

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

3. (a) PRINT FULL NAME JOSEPH EHLEN

3. (b) If veteran, No name war \_\_\_\_\_

3. (c) Social Security No. No

4. Sex Male 5. Color or Race Wht.

6. (a) Single, widowed, married, 2 divorced Wid.

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased June 13 1870  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4th  
year 1945 hour 1:20 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 10/27/45  
\_\_\_\_\_ 19\_\_\_\_ to 11/4/45 19\_\_\_\_  
that I last saw him alive on 11/4/45 19\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 4 Days 23  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Casper Ehlen

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

14. Maiden name Elizabeth Kemp

15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant Frank Ehlen

(b) Address 4427 Tholosan Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Assumption Cem. Mattese Mo.

18. (a) Signature of funeral director St. Bernhardt

(b) Address 3819 S. Grand Blv.

19. (a) NOV 6 1945 (Date received local registrar) (b) St. Bernhardt (Registrar's signature)

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 James J. Smith 1515 Lafayette 11/5/45  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

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**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.....

*DE Morris*

Licensed Embalmer No.....

33.60

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.**