

FILED DEC 31 1945  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10314

1. PLACE OF DEATH

(a) County St. Louis Mo  
(b) City or town St. Louis  
(c) Name of hospital or institution \_\_\_\_\_  
(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 Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 615 Walnut St. (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Roy Fedlich

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

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation Free Worker

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Dr. Carl [unclear]

(b) Address Anatomical Board 3500 [unclear]

17. (a) (Burial, cremation, or removal) (City or town) (County) (State) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director [unclear]

(b) Address 3500 [unclear]

19. (a) NOV 28 1945 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death)

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

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

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 \_\_\_\_\_

23. Signature [unclear] (M.D. or other)

Address [unclear] Date signed 11/19/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1. Oedema of Brain  
2. Aortic  
Atherosclerosis

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

SC08D

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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.....

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.**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10314**

## 1. PLACE OF DEATH:

(a) County.....  
 (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**  
(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)

3. (a) PRINT FULL NAME **Roy Redlich**3. (b) If veteran, name war **World War # 2** 3. (c) Social Security No. **Unknown**4. Sex **Male** 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 **October 11 1886**  
(Month) (Day) (Year)8. AGE: Years **59** Months **0** Days **20** If less than one day  
hr. min.9. Birthplace **St. Louis - Missouri**  
(City, town, or county) (State or foreign country)10. Usual occupation **Shoe Worker**

11. Industry or business.....

12. Name **William E. Redlich**13. Birthplace **Marine Illinois**  
(City, town, or county) (State or foreign country)14. Maiden name **Rowena Timmons**15. Birthplace **Jerseyville Ill.**  
(City, town, or county) (State or foreign country)16. (a) Informant **Harry Redlich**(b) Address **Jerseyville, Ill.**17. (a) **Removal** (b) Date thereof **1-25-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Jerseyville, Ill.**18. (a) Signature of funeral director **Albert H. Hoppe**(b) Address **4700 Washington Blvd.**19. (a) **Nov. 28-46** (b) **J. F. Preced**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....  
 (c) City or town **St. Louis** **25**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **615 Walnut St.**  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **1**  
year **1945** hour **10** minute **20 AM.**21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....  
that I last saw him alive on....., 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

**1. Edema of Brain**  
**2. Alcoholism**

Due to.....  
 Due to.....

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) (e) Means of injury.23. Signature **Alfred J. Perry** (M. D. or other)  
Address **Deputy Registrar** Date signed **11-19-46**

Reclaimed from Anatomical Society - 1-24-46

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

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES

35771

**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.**