

**FILED** NOV 19 1945  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9670**

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

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:  
Park Lane Memorial Hosp. 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

3. (a) PRINT FULL NAME Marie Rike

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Herbert

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased March 25 1895  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>7</u>	<u>11</u>	_____ hr. _____ min.

9. Birthplace Austria 11  
(City, town, or county) (State or foreign country)

10. Usual occupation Press Operator

MOTHER FATHER

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace Unknown 11  
(City, town, or county) (State or foreign country)

16. (a) Informant Herbert Rike

(b) Address 771 Ruprecht

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Wacker Alderle  
3634 Gravois Ave.

(b) Address \_\_\_\_\_

19. (a) NOV 8 1945 (b) J. J. Brunck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town St. Louis Lemay 9  
(If outside city or town limits, write "RURAL")

(d) Street No. 771 Ruprecht  
(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 6  
year 1945 hour 7 minute 38 A.M.

21. I hereby certify that I attended the deceased from 10-17 1945 to 11-6 1945  
that I last saw her alive on 11-6-45 and that death occurred on the date and hour stated above.

Immediate cause of death General Carcinoma metastatic

Due to Cervical Ca. (gland)

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

Other conditions 55  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

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

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

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)

(c) Means of injury \_\_\_\_\_

23. Signature J. J. Brunck (M. D. or other) md.  
Address 4930 Underwood Blvd Date signed 11-6-45

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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 *Robert Wheeler*.....

Licensed Embalmer No. *2128*.....

P. O. Address *Houston*.....

**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.**