No. 2
-9-4-41
-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 17 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38469

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 2610

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
(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 96

(c) City or town Webster Groves 7
(If outside city or town limits, write "RURAL")

(d) Street No. 617 Sunnyside Ave. 4
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Lucile A. Fehlig.

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

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

4. Sex F. 1

5. Color or race W.

6. (a) Single, widowed, married, divorced M. 0

6. (b) Name of husband or wife J. Frank Fehlig

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Unknown (Month) (Day) 1888 (Year)

8. AGE: Years 57 | Months Unknown | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation At Home

11. Industry or business .....

FATHER
12. Name Alexander Miller
13. Birthplace ..... (City, town, or county) Germany. (State or foreign country)

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

16. (a) Informant Mr. J. Frank Fehlig.

(b) Address 617 Sunnyside Ave.

17. (a) Burial. (Burial, cremation, or removal) (b) Date thereof 11-15-45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) 11-15-45 (Date received local registrar) (b) E. J. McGarran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 13th year 1945 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased from Nov. 13, 1943 to Nov. 13, 1945 that I last saw her alive on Nov. 12, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhage into gastro-intestinal tract	48 Hrs.
Due to Gastric [illegible]	Uncertain
Due to	
Other conditions (Include pregnancy within 3 months of death): Fractures of Pelvic Bones. Diabetes Mellitus.	23 days. Uncertain

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations .....
Of autopsy Confirmed diagnosis given above.

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) 130

(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 G. O. Brown (M. D. or other) M.D.

Address 1325 S. Grand Date signed 11/13/45

(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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Linden Blv

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

U. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2610

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:

(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Lucile A. Fehlig

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

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

8. AGE: Years 57 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 3 year 1945 hour minute M.

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

Immediate cause of death Hemorrhage from Stomach

Due to Gastric Ulcer

Due to

Other conditions (Include pregnancy within 3 months of death) Fracture of Pelvis

Major findings:
Of operations Diabetes mellitus

Of autopsy Confirmed diagnosis given above

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) Fracture of Pelvis

(b) Date of occurrence Oct. 21 or 25, 1945

(c) Where did injury occur? Webster Groves (City or town) Mo. (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury Fell down steps.

23. Signature [illegible] Brown (M. D. or other) M.D.

Address 1325 S. Grand Date signed 11/24/45

SUPPLEMENTARY

SUPPLEMENTARY INFORMATION SUGGESTED

38469