

S. No. 2  
M-5-43  
7-5-17-39  
P I X36671

FILED FEB 21 1946  
318

Primary Registration District No. 1003

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:  
6129 Vermont ave.  
(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 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6129 Vermont ave.  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elizabeth Sander  
3. (b) If veteran, name war no  
3. (c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife John Sander  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 17 1863  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 27  
year 1946 hour 4 minute 45 A. M.  
21. I hereby certify that I attended the deceased from Ext.  
15 1946 to Jan 27 1946  
that I last saw her alive on Jan 26 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
82 9 10 hr. min.

Immediate cause of death arteriosclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Oakville Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation At Home

11. Industry or business \_\_\_\_\_  
12. Name Charles Molt  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Marie Paulus  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Albert Guth  
(b) Address 6129 Vermont, ave.  
17. (a) Burial (b) Date thereof Jan. 30, 46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Matthews Cemetery  
18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.  
(b) Address 7814 S. Broadway  
19. (a) JAN 28 1946 (b) J. F. Bredeek  
(Date received local registrar) (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 S. M. Mott (M. D. or other) \_\_\_\_\_  
Address 6129 Vermont Date signed 1-28-46

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

3055

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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..... *Louis C. Hoffmeister* .....

Licensed Embalmer No..... *3871* .....

P. O. Address..... *7814 S Broadway* .....

**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.**