

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
X36871

**FILED JUN 6 1946**  
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
5904 Julian Avenue  
(If not in hospital or institution, write street number or location)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 5904 Julian Avenue  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Auguste A. Lang

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

4. Sex F. 5. Color or race W.

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

6. (b) Name of husband or wife August J. Lang 6. (c) Age of husband or wife if alive 86 years

7. Birth date of deceased March 17 1863  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26  
year 1946 hour 10: minute 30 P. M.

21. I hereby certify that I attended the deceased from May 9 1946 to May 26 1946  
that I last saw him alive on May 20 1946  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>2</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death Hemorrhage of stomach 5 hrs  
ulcer of stomach 1 mo.

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

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

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

10. Usual occupation Housewife

Other conditions (Include pregnancy within month of death) Fracture Rt femur

Major findings: Fracture of femur

Of operations \_\_\_\_\_

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

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

12. Name Henry C. Eggers

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

14. Maiden name Doretta Ulrich

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. Luella Stolz

(b) Address 5904 Julian Avenue

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 5/29/46  
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) May 7, 46 000

(b) Date of occurrence Fracture Rt femur

(c) Where did injury occur? Fracture in own room at home due to weakness  
(City or town) (County) (State)

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

18. (a) Signature of funeral director Alexander Bone

(b) Address 6175 Delmar

19. (a) MAY 27 1946 (Date received local registrar) (b) J. F. Bredbeck (Registrar's signature)

While at work? No (Specify type of place) (c) Means of injury To

23. Signature J. F. Bredbeck (M. D. or other) \_\_\_\_\_  
Address 839 E. 1st St Date signed May 27/46

Dr. Wm Langon  
Plymouth + Grafton

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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: *Thomas R Fenwick*

Licensed Embalmer No. *3793*

P. O. Address *6175 Delmar*

**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.**