

FILED JUN 6 1946

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4884**

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:  
**City Infirmiry Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **5-16-46 To**  
(Specify whether  
 In this community **5-31p46**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **4884**  
 (c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **5600 Arsenal Street**  
(If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Rose Ringhoefer**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **2andney**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31**, year **1946** hour **1** minute **20P** M.

21. I hereby certify that I attended the deceased from **May 16, 1946** to **May 31, 1946**, that I last saw her alive on **May 31, 1946**, and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**

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

6. (c) Age of husband or wife if alive **34** years

7. Birth date of deceased: **21** (Month) **23** (Day) **1914** (Year)

Immediate cause of death **Carcinoma of left lung with metastasis to brain**

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

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

Other conditions **H7**  
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	<b>31</b>	<b>6</b>	<b>8</b>	_____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business **Self**

12. Name **Baldasare Tedeschi**

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

14. Maiden name **Caterina Seife**

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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

16. (a) Informant **City Infirmiry Records**

(b) Address **5800 Arsenal Street**

17. (a) **Burial** (b) Date thereof **June 3 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Rensick - Nehaus**

(b) Address **1431 Union Blvd**

19. (a) **JUN 1 1946** (b) **J. F. Bredeck**  
(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 **J. F. Bredeck** M. D. or other \_\_\_\_\_  
 Address **5600 Arsenal** Date signed **5/31/46**

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

MOTHER FATHER

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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

*Frank H. Nicklaus*

Licensed Embalmer No. *2915*

P. O. Address *St. Louis, Mo.*

**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.