

FILED JUN 20 1946
Registration District No. 318

Primary Registration District No. 1003

State File No. _____

Registrar's No. 5070

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS, MO. HOSPITAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MICITY INFIRMARY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5/16/46 to 6/4/46
(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 MO.
(If outside city or town limits, write "RURAL")
(d) Street No. 3705^a LEE AVE.
(If rural, give location) 17 109 10
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CAROLINE NAUE

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 WIDOW
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 7 17 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 10 17 hr. min.

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

10. Usual occupation HOUSEWIFE.

11. Industry or business _____

MOTHER FATHER { 12. Name CHARLES
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name CAROLINE
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant CITY INFIRMARY RECORDS

(b) Address 5800 Arsenal

17. (a) Burial (b) Date thereof June 8 46
(Burial, cremation, or removal) (Month) (Day) (Year)
Bethlehem Cem.

(c) Place: burial or cremation _____

18. (a) Signature of funeral director J. Ambrose

(b) Address 4053 Leavelle

19. (a) JUN 6 1946 (Date received local registrar) J. F. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 4
year 1946 hour 10 minute TOP P.M.

21. I hereby certify that I attended the deceased from 5/5-1946 to 6-4-1946

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatous liver, gall bladder, lungs, mesenteric nodes.

Due to Primary liver

Due to _____

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

Major findings: _____ Of operations _____

Of autopsy Carcinomatous liver, lung, gall bladder, mes. nodes

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. Bredek (M. D. or other)

Address 5800 Arsenal St Date signed 6/2/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Henry Eymann*

Licensed Embalmer No..... *1284*

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

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

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

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No.

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME *Caroline nave*

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 *wid*

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

7. Birth date of deceased *July 17* (Month) (Day) (Year)

8. AGE: Years *73* Months *10* Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) Date of death *6 1946* (Month) (Day) (Year)

(b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) *J. F. Bredeest* (Registrar's signature) (Date received local registrar) _____

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above. _____ immediate cause of death.

Duration _____
Due to _____
Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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) _____
(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 _____ (M. D. or other) _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

RECORD PERMANENTLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 28 1946

22049