

FILED JUL 26 1946
318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **6067**

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:
4303 West Clayton Ave. 1
(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

3. (a) PRINT FULL NAME PT. HENRY ARTHUR PRESLER

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 22, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 10 16 hr. _____ min. _____

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

10. Usual occupation Meat Inspector, City of St. Louis

11. Industry or business _____

12. Name Samuel Presler

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

14. Maiden name Kezia Wier
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Alma Presler

(b) Address 7520 Ahern Avenue

17. (a) removed (b) Date thereof July 10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hannibal, Mo.

18. (a) Signature of funeral director Ally Anderson

(b) Address 6175 Delmar

19. (a) JUL 9 1946 (b) J. F. Breda
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 7520 Ahern Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8th
year 1946 hour 7:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from 7-8, 1946 to 7-8, 1946.
that I last saw him alive on 7-8, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to _____
Due to _____
Other conditions _____
(Exclude pregnancy within 7 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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? _____

(Specify type of place) _____
While at work? _____ (i) Means of injury _____
23. Signature Harol Steele (M. D. or other) _____
Address 1700-A Tower Grove Ave. Date signed 7-9-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

96
23
NR

[Handwritten signature and notes over medical certification section]

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 Geo. E. McCulloch
Licensed Embalmer No. 2460
P. O. Address 6173 Dilmar

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.

Registration District No. 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:

(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)

3. (a) PRINT FULL NAME

Henry A. Presler
3. (b) If veteran, name war..... 3. (c) Social Security No.:

4. Sex m 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.....

7. Birth date of deceased Aug 22 1906
(Month) (Day) (Year)

8. AGE: Years Months Days (if less than one day) hr. min.
76

9. Birthplace Unknown
(City, town, or county) (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) J. F. Bredeck (Registrar's signature)
AUG 5 1948

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 Aug year 1946 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from 1946 to 1946, 19..... that I last saw him alive on Aug 22 1946 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) (c) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

25623