

FILED JUL 18 1946

Registration District No.

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: MARIAN HOSPITAL. 0  
(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... Mo. (b) County.....  
(c) City or town... ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6567 SMILEY AV. D  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7/14 day 14 / 46  
year..... hour 7 minute 05 AM.  
21. I hereby certify that I attended the deceased from July 26  
..... 1946 to 7/14 1946;  
that I last saw him alive on 7/14 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Cerebral hemorrhage  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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?

While at work?..... (Specify type of place) (e) Means of injury.....  
23. Signature... L. Berg (M. D. or other) MD  
Address... 2253 Hlbrake Date signed 7/14/46

3. (a) PRINT FULL NAME NETTIE THONE  
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, WIDOWED

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

7. Birth date of deceased SEPT. 18 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 9 26 hr. min.

9. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

11. Industry or business.....

12. Name FRANK HAKE

13. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

14. Maiden name ERKASTENA BACKHANS

15. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. John M. HENKENIUS  
(b) Address 6567 SMILEY AV.

17. (a) BURIAL (b) Date thereof JULY 16 - 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FORT WAYNE, IND.

18. (a) Signature of funeral director E. J. Schuur  
(b) Address 3125 Lafayette Av.  
19. (a) JUL 15 1946 (Date received local registrar) J. F. Budeck (Registrar's signature)

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

MOTHER FATHER

24642

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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 *Joseph B. Vallmer*  
Licensed Embalmer No. *4114*  
P. O. Address *St. Louis 4, 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.**