

S. No. 2
M-5-43
v. 5-17-39
I X38671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34700**
Registrar's No. **2027**

Registration District No. **317** Primary Registration District No. **3070**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Webster Groves**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7 Schultz Rd.
(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 **Missouri** (b) County **St. Louis** **96**
(c) City or town **Webster Groves** **7**
(If outside city or town limits, write "RURAL")
(d) Street No. **7 Schultz Rd.** **4**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **Katherin Johannes**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **10** day **10**
year **1946** hour **7** minute **45** P.M.

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Charles P. Johannes**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **12 17 1884**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **January 21**, 19**41** to **October 10**, 19**46**
that I last saw her alive on **October 10**, 19**46**,
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
61 10 13 hr. _____ min.

Immediate cause of death
Chronic Myocarditis **93.D** **9** years
Due to **Arteriosclerosis** **9** years

9. Birthplace **Alton Illinois**
(City, town, or county) (State or foreign country)

Due to _____
Other conditions: **Uremia** **3** days
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

11. Industry or business _____

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **Thomas McAuliff**
13. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Amelia Meyer**
15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Nan Burkhart**
(b) Address **7 Schultz Rd.**

17. (a) **Burial** (b) Date thereof **10-12-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**
18. (a) Signature of funeral director **Weick Bro. Und. Co.**
(b) Address **2201 S. Grand Bl.**

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? **0**
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature **Elmer H. Alford** M. D. or other **MD**
Address **Webster Groves, Mo.** Date signed **10/11/46**

19. (a) **10-14-46** (b) **Ruth J. Alford**
(Date received local registrar) (Registrar's signature)

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.....

James R. Dunn

....., Registered Apprentice No. 403

working under my personal supervision.

Signed.....

Wm. A. Stewart

Licensed Embalmer No. 3722

P. O. Address. 412 Duchouquette St.

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.