

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Loehn
(c) Name of hospital or institution: None, Clayton & Barter Roads
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. None
In this community 39 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Loehn
(d) Street No. Clayton & Barter Rd's.
(e) Citizen of foreign country? No.
If yes, name country _____

3. (a) PRINT FULL NAME Eliza E. Soehn
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Theodore Soehn
6. (c) Age of husband or wife if alive 1877 years

7. Birth date of deceased May 5 1877
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days 17
If less than one day hr. min.

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

10. Usual occupation Retired house wife

11. Industry or business At home

MOTHER FATHER { 12. Name John Pryor
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant Edgar Soehn
(b) Address Valley Park Mo. R. 1

17. (a) Burial (b) Date thereof Dec. 21-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Trinity Cen. Althaus Mo.

18. (a) Signature of funeral director Schrader Funeral Home
(b) Address Baldwin Mo.
19. (a) 12-21-46 (b) Ruth J. Allen, R.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 18
year 1946 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 1944 to Dec 18 1946
that I last saw her alive on Nov. 15 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis with myocardial degeneration Duration 2 yrs.
Due to Arterial Hypertension 5 yrs.
Due to 930

Other conditions 930
(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? _____
(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 21
23. Signature Robert H. Meadows M.D. or other So
Address 250 Central, Clayton Mo Date signed 12-19-46

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.....

Theo Schrader
..... Licensed Embalmer No. *3066*

..... P. O. Address *Baltimore, Md.*

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.