

No. 2  
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5-17-39  
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FILED MAR 14 1947  
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State File No. \_\_\_\_\_  
Registrar's No. 2240

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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:  
4965 Bonita /  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_ life \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_ 000  
 (c) City or town St Louis  
(If outside city or town limits, write "RURAL") 147  
 (d) Street No. 4965 Bonita  
(If rural, give location) 9  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Minnie Saks

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 3  
 year 1947 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept. 1  
 \_\_\_\_\_, 1947 to MARCH 3, 1947.  
 that I last saw her alive on MARCH 2, 1947.  
 and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Joseph 6. (c) Age of husband or wife if alive 77 years  
 7. Birth date of deceased October 8th 1867  
(Month) (Day) (Year)

Immediate cause of death Arterial Fibrillation. 2 days  
 Due to Acute myocarditis 3 mon.  
 Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
79 2 25 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions Asthma (bronchial) 3 mon.  
(Include pregnancy within 3 months of death)

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

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name August Riepe  
 13. Birthplace not known Germany 4  
(City, town, or county) (State or foreign country)  
 14. Maiden name not known  
 15. Birthplace not known 4  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mrs. Edna Lemp  
 (b) Address 4965 Bonita

17. (a) burial (b) Date thereof 3/5/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Laurel Hill Cem

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature Eugene H. Edde (M. D. or other) M.D.  
 Address 4971 Chipewo St. Date signed 3/4/47

18. (a) Signature of funeral director J L Ziegenhein & Sons  
 (b) Address 7027 Gravois

19. (a) MAR 5 1947 J. F. Breda  
(Date received local registration) (Registrar's signature)

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

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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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address Overland 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.