

No. 2  
12-45  
5-17-39  
1747070

FILED APR 21 1947

318

Primary Registration District No. **1000**

Registrar's No. **3875**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.

(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff Memorial  
(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 Madison

(c) City or town St. Louis.  
(If outside city or town limits, write "RURAL")

(d) Street No. 2340 Park.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELIZABETH HUETHER

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 Single.

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 14 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>7</u>	<u>26</u>	hr. _____ min. _____

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

10. Usual occupation nil

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

MOTHER FATHER

12. Name Adam Huether.

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

14. Maiden name Mary Klocker.

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

16. (a) Informant Edward Brodway.

(b) Address 4365 Lindell.

17. (a) Burial. (b) Date thereof 11/11/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery.

18. (a) Signature of funeral director Edith E. Ambruster.

(b) Address 4234 Manchester.

19. (a) APR 13 1947 (b) J. P. Brudeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th  
year 1947 hour 7:50 minute P M.

21. I hereby certify that I attended the deceased from 4/7/47  
\_\_\_\_\_, 19\_\_\_\_, to 4/10/47, 19\_\_\_\_;

that I last saw h. er alive on 4/10/47, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration 5 days

Due to Corony Occlusion 5 days

Due to Arteric sclerotic Heart Disease years

Other conditions (Include pregnancy within 3 months of death) 93

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)  
MEANS OF INJURY: \_\_\_\_\_

23. Signature J. P. Brudeck (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Date 4/10/47

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

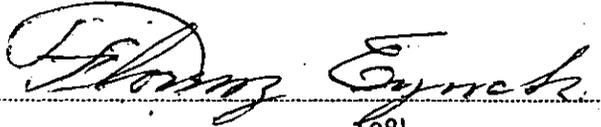
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**STATEMENT BY LICENSED EMBALMER**

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..... 

Licensed Embalmer No..... 1284

P. O. Address..... St. Louis, 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.

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)

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.....

3. (a) PRINT FULL NAME

*Elizabeth Huether*

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... min.

9. Birthplace..... (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. Bredek* (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *1-0*  
year *1947* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19.....  
that I last saw him alive on..... 19.....  
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) (e) Means of injury.....

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

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

**SUPPLEMENTARY**

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

15206

2016 