

National Office of Vital Statistics  
FILED OCT 24 1947 318

State File No. \_\_\_\_\_

Registrar's No. 9264

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

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County MISSOURI  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2758 ANN  
(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 ADC  
(c) City or town ST. LOUIS 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2526 CALIFORNIA 9  
23 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES HEHWIG  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month OCT. day 8  
year 1947 hour 11 minute 25 P.M.

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWER  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: JAN 30 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
71 8 8 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: fracture of skull  
causing hemorrhage when he fell  
from the flight of step from the  
staircase to the basement of the  
home of his sister-in-law  
at 2758 Ann Ave on Oct 8, 1947  
about 8:30 P.M.  
Duration \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace: ST. LOUIS MO  
(City, town, or county) (State or foreign country)

10. Usual occupation: Day Laborer

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

12. Name: CHARLES HEHWIG

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

14. Maiden name: UNKNOWN

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

16. (a) Informant: ROSE JULIA LOEB  
(b) Address: 2758 ANN

17. (a) BURIAL (b) Date thereof: OCT 11, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: NEW ST. MARCUS  
Thomas Kutera, son

18. (a) Signature of funeral director: \_\_\_\_\_  
(b) Address: 2906 GRAVOIS

19. (a) OCT 9 1947 (b) J. F. Bradner  
(Date received local registrar's certificate) (Registrar's signature)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): Accident

(b) Date of occurrence: OCT 8 1947

(c) Where did injury occur?: ST. LOUIS MO  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home  
(Specify type of place)

(e) Means of injury: fall

23. Signature: Patrick J. Taylor (M. D. or other) \_\_\_\_\_

Address: Deputy Coroner Date signed: 10.9.47

PHYSICIAN

Underline the cause of which death should be charged statistically.

WHITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 25 1988

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

*Leo J. Budde*

Licensed Embalmer No.

*3989*

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. 914

Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis  
(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  
3. (a) PRINT FULL NAME Charles Helweg  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced med  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 30 (Month) (Day) (Year)

8. AGE: Years 71 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation Day Laborer

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredes (Registrar's signature)  
(Date received local registrar)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

SUPPLEMENTARY

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

S-35825