

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(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
(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 **LOUIS EHRLER**

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

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

6. (b) Name of husband or wife **Carrie Ehrler** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug. 8th 1871**
(Month) (Day) (Year)

8. AGE: Years **76** Months **5** Days **29** If less than one day hr. _____ min. _____

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

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Henry Ehrler**

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

14. Maiden name **Fredericka Miller**

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

16. (a) Informant **Mrs. Caroline Hopman**

(b) Address **2517a N. Jefferson Ave.**

17. (a) **burial** (b) Date thereof **2-9-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Lebanon Cemetery**

18. (a) Signature of funeral director **A. Kron L&J. Co.**

(b) Address **2707 N. Grand Blvd.**

19. (a) **9 1948** (b) **J. F. Brudack**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2517a N. Jefferson Ave.**
Memorial 20 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **7th** year **1948** hour **4** minute **15** A.M.

21. I hereby certify that I attended the deceased from **2/1/48** to **Feb. 7th 19 48**
that I last saw him alive on **Feb. 7th 19 48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia** Duration _____

Due to **Septicemia**

Due to **Pneumonia**

Other conditions (Include pregnancy within 3 months of death) **107**

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 **1515 Lafayette** **1/2/48** (Date signed)
Address _____

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

MOTHER FATHER

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

Stanley H. Dixon

Licensed Embalmer No.

4193

P. O. Address

St. Louis

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.