

147  
7-39

FILED JUL 15 1948

318

1003

Registrar's No. **5950**

Registration District No. ....

Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County St. Louis Mo  
(b) City or town St. Louis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: C.T. Hospital #14 0  
(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 F. Bartsch

3. (b) If veteran, name war None 3. (c) Social Security No. ....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased Jan 16 1879  
(Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days 16 If less than one day  
..... hr. .... min.

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

10. Usual occupation Wood worker

11. Industry or business.....

12. Name Edward Bartsch  
13. Birthplace Austria 4  
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Roerich  
15. Birthplace Austria 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Bertha Bartsch  
(b) Address 2017 Farrar

17. (a) Burial (b) Date thereof 7 6 48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Edw. Koch + Son  
(b) Address 3516 N. 14th

19. (a) JUL 3 1948 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mo  
(c) City or town St. Louis, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 26 2017 Farrar  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2  
year 1948 hour 5 minute 30 P M.

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

Immediate cause of death Cerebral Apoplexy  
Duration

Due to.....  
Due to.....

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

PHYSICIAN  
Major findings:  
Of operations.....  
Of autopsy.....  
Underline the cause of 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?.....  
(Specify type of place)

While at work?..... (e) Means of injury 3  
23. Dr. E. E. Hughes (M. D. or other)  
Address..... Date signed 7/6/48

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

MOTHER FATHER

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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 \_\_\_\_\_

*J. Allen Smith*

Licensed Embalmer No. \_\_\_\_\_

*4053*

P. O. Address \_\_\_\_\_

*W. Lewis*

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.