

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **34404**
Registrar's No. **9359**

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:
Lutheran Hospital
(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 No. **Mo.** (b) County **Beth**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **5453 Delor St.** **9**
(If rural, give location)
(e) Citizen of foreign country? **14** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CORA LEWEDAG**

3. (b) If veteran, name war **None** 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 **June 5 1885**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 4 23 hr. min.

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

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Charles Lewedag**

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

14. Maiden name **Marie Feimsoth**

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

16. (a) Informant **Miss Florence Lewedag**

(b) Address **5453 Delor St.**

17. (a) **Burial** (b) Date thereof **11-1-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cem.**

18. (a) Signature of funeral director **Kriegshauser Und. Co.**

(b) Address **4228 S. Kingshighway Bl.**

19. (a) **OCT 29 1948** (b) **J.B. Saater**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **28**
year **1948** hour **5:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **10/25/48**
_____, 19____, to **10/28**, 19____;
that I last saw h_____ alive on **10/28**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
**Paralytic ileus
Aspiration pneumonia
followed a cholecystomy
for gall stones**
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations **gall stones - small white
gall bladder thick & chon**
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)
(c) Means of injury _____

23. Signature **Ralph Berg** (M. D. or other) _____
Address **3203 S Grand** Date signed **10/29/48**

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

MOTHER FATHER

1130-113
3103 So. ...
1130-113

Price

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..... *Edwin M. Bennett*

Licensed Embalmer No. *3024*

P. O. Address.....

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.