

No. 300
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5-17-39
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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

34783
State File No. _____
Registrar's No. **9141**

FILED OCT 30 1948

Registration District No. **318** Primary Registration District No. _____

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:
Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 weeks 4 days**
(Specify whether _____)
In this community **67 years**
years, months or days)

3: (a) PRINT FULL NAME **Elizabeth Twellman**
(b) If veteran, name war _____ (c) Social Security No. **489-05-3960**
4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 12 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 7 9 hr. min.

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

10. Usual occupation **Forelady**

11. Industry or business **Wholesale Dry Goods**

12. Name **John H. Twellman**

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

14. Maiden name **Johanna Landwehr**

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

16. (a) Informant **Miss Anna Twellman**

(b) Address **3952 No. Eleventh Street**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct. 25 1948**
(Month) (Day) (Year)

(c) Place: burial or cremation **New Bethlehem Cemetery**

18. (a) Signature of funeral director **REIDERWIEDEN F. HOME, INC.**
(b) Address **1936 St. Louis Ave.**

19. (a) **OCT 22 1948** (Date received local registrar) (b) **J. B. Pasater** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3952 No. Eleventh Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **21**
year **1948** hour **9** minute **50** A. M.
21. I hereby certify that I attended the deceased from **Sept. 26,**
1948 to **Oct. 21,** 1948;
that I last saw her alive on **Oct. 21,** 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death **Exhaustion**

Due to **Cerebral hemorrhage**

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 **Lemard J. Kopp** (M. D. or other) _____

Address **4411 N. Newstead Ave.** Date signed **10/22/48**

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

MOTHER FATHER

Dr. Kepp
c/o Christian Hospital

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 Walter Paulson

Licensed Embalmer No. 4114

P. O. Address 1936 St. Louis Ave

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.