

FILED DEC 31 1948

Registration District No. 217

Primary Registration District No. 3 D 163

Registrar's No. 2786

1. PLACE OF DEATH:

(a) County St. Louis County
 (b) City or town CLAYTON
 (If outside city or town limits, write "RURAL" and name of township)
ST. LOUIS COUNTY HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 DAYS
 In this community 8 MONTHS
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS CO.
 (c) City or town ROBERTSON
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rt #1 Box 20
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ALMA WARMANN

3. (b) If veteran, name war NONE
 3. (c) Social Security No. 494-03-6878

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

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10 24 07
 (Month) (Day) (Year)

8. AGE: Years 41 Months 1 Days 6
 If less than one day hr. _____ min. _____

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

10. Usual occupation SHOE WORKER

11. Industry or business SAMUEL SHOE CO.

12. Name GEORGE WARMANN

13. Birthplace ST. LOUIS MISSOURI
 (City, town, or county) (State or foreign country)

14. Maiden name MAMIE WEIDNER

15. Birthplace ST. LOUIS MISSOURI
 (City, town, or county) (State or foreign country)

16. (a) Informant Russell Warmann

(b) Address Rt #1 Box 20 Robertson Mo

17. (c) BURIAL (b) Date thereof 12-4-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ZION CEMETERY

18. (a) Signature of funeral director COLLIER FUNERAL HOME

(b) Address 10123 St. Charles Ave. R.D.

19. (a) 12-4-48 (b) THURLOUGH LININGER
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 30
 year 1948 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from NOVEMBER 20, 1948, to NOVEMBER 30, 1948; that I last saw her alive on NOVEMBER 30, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death cerebral convulsion & cerebral intracranial hemorrhage
 Due to _____
 Due to _____

Other conditions epd fractures both legs
 (Include pregnancy within 3 months of death)

Major findings: Of operations 1700
 Of autopsy same as above

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

(a) Accident, suicide, or homicide (specify) homicide
 (b) Date of occurrence Nov. 20, 1948
 (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?

HIGHWAY STROCK BY
 While at work? no (Specify type of place) (e) Means of injury AUTO

23. Signature R. L. Coulter Jr. (M. D. or other) _____
 Address 6015 BRENTWOOD, C Date signed 11-30-48

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

6324

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..... *Sheldon Collier*.....

Licensed Embalmer No. *3382*.....

P. O. Address *10123 St. Charles*.....

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. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St Louis Co
(b) City or town Clayton
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Alma W. Wermann

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

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

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

7. Birth date of deceased Oct 24 (Month) (Day) (Year)

8. AGE: Years 41 Months _____ Days _____ (Unless than one day) hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) No.

10. Usual occupation _____

11. Industry or business _____

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-1-48 (b) Theroid L. L... (Date received local registrar) (Registrar's Signature)

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 1948 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 _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

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) (e) Means of injury _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-41997

1-1-1997