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BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				
d. FULL NAME OF HOSPITAL OR INSTITUTION 3614 Dunnica				d. STREET ADDRESS (If rural, give location) 3614 Dunnica Street				
3. NAME OF DECEASED (Type or Print) Lizzie			a. (First)		b. (Middle)		c. (Last) Ehrlich	
4. DATE OF DEATH January 2, 1949		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH November 29, 1869		9. AGE (In years last birthday) 79		
5. SEX Female		8. COLOR OR RACE White		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Champion City, Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.				
13a. FATHER'S NAME Benjamin Otte			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Henry H. Ehrlich		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Theo. Euler, 3614 Dunnica				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chronic Myocarditis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>about 1 year</i>		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chronic Arteriosclerosis</i>				<i>about 5 years</i>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>42</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <i>Oct. 1, 1948</i> , to <i>Jan 2, 1949</i> , that I last saw the deceased alive on <i>Jan 2, 1949</i> , and that death occurred at <i>12-10 P.M.</i> from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <i>W. H. Meisner - M.D.</i>				23b. ADDRESS <i>3606 Francis St.</i>		23c. DATE SIGNED <i>Jan 3, 1949</i>		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE January 5, 1949		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 6 1949 <i>J. B. Foster</i>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden R. Home, Inc. 1936 St. Louis				

*Dr. H. C. Weinberg*

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Paul H. 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.