

FILED MAR 19 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

10473

State File No.

#93438

318

1003

Registrar's No. 2335

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 <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis, Mo.</u>)		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		17 _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.</u>				d. STREET ADDRESS (If rural, give location) <u>1012 WALL ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) _____		b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>March 12, 1949</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MARCH-19-1872</u>	
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN. NEUHERZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Johanna Mueller 1012 Wall St.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>97</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>yes -</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>H&O</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		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 <u>2/4/49</u> , 19 <u>49</u> , to <u>3/12/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3/12/49</u> , 19 <u>49</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W.M. Turner, M.D.</u>				23b. ADDRESS <u>1515 Lafayette Ave.,</u>		23c. DATE SIGNED <u>3/12/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MARCH 15-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FRIEDENS CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>	
DATE REC'D BY LOCAL REG. <u>MAR 14 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Kasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Diidrich F. Home 8319 HALLS FERRY RD.</u>			

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

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.

Signed _____

Albert G. Hoppe

Signed _____

Student Embalmer

Licensed Embalmer No. _____

2991

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.