

REGD OCT 14 1939
Registration District No. 791

Primary Registration District No. _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH: 1008 2
(a) County St. Louis Mo.
(b) City or town St. Louis Mo.
(c) Name of hospital or institution: 803 Allen Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 55 Years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Catherine Suren 6-50
8. (b) If veteran, name war _____ 8. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Herman Suren 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 23 1861
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>78</u>	<u>4</u>	<u>11</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business At Home.

12. Name Theodore Schweer
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Herman Suren
(b) Address 803 Allen Ave.

17. (a) Burial (b) Date thereof Sept 7th/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation S.S. Peter & Paul

18. (a) Signature of funeral director Phoedutis
(b) Address 2906 Gravois Ave.

19. (a) SEP 6 1939 (b) _____
(Date received local registrar) (Date of death)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis.
(If outside city or town limits, write "RURAL")
(d) Street No. 803 Allen Ave. 23
(If rural, give location)
(e) If foreign born, how long in U. S. A.: 55 Years. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
year 1939 hour 7 10 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from Aug 2-1939
to Sept 4 1939
that I last saw her alive on Sept 4- 1939
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of Descending Colon with infection of colon Bacilli
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
6 weeks
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) (a) Means of injury _____
23. Signature Arthur H. Wengel, M.D. (M. D. or other)
Address 1845 S. 1st St Date signed 9-5-39

may & change
S-L

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.....

Leo Bidde

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Leo Bidde

Licensed Embalmer No. *3989*

P. O. Address *St. Louis, Mo.*

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, above space should be left blank.