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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41417

Registration District No. 791

Primary Registration District No.

Registrar's No. 10540

1. PLACE OF DEATH: 1003

(a) County 1

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 hrs. (Specify whether
In this community 35 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County

(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4708 S. Compton ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Charles A. Aschenbrenner 251

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frieda

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Jan. 15 (Month) 1872 (Day) (Year)

8. AGE: Years 67 | Months 10 | Days 22 | If less than one day hr. min.

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

10. Usual occupation Chauffer

11. Industry or business 1

FATHER
12. Name Charles Aschenbrenner 1
13. Birthplace Quincy (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Unknown 1
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frieda Aschenbrenner
(b) Address 4708 S. Compton ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11. 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director [illegible] M. L. Co.
(b) Address 7814 S. Broadway

19. (a) DEC 9 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7 year 1939 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to Chronic Interstitial	
Due to Nephritis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 131	
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? (Specify type of place)
While at work? (e) Means of injury 4

23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed 5.9.39

(Licensed Embalmer's Statement on Reverse Side)

Copy

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 Lucas C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Bro

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.