

JAN 12 1940

Registration District No. 701

Primary Registration District No.

Registrar's No. 10745

1. PLACE OF DEATH: 1003

(a) County _____

(b) City or town St. Louis

(c) Name of hospital or institution:
St. Louis City Hospital No. 1

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Mamie Rueweler

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Fred Rueweler

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

7. Birth date of deceased Sept 6 1859
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gurtrude Dean

(b) Address 2507 Belt Ave

17. (a) Burial (b) Date thereof 12-18-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) DEC 16 1939

(Date received local registrar) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 6

(d) Street No. 2507 Belt Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1939 hour 7.15 minute a M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Accidents of the Digestive System

Due to Arteriosclerosis

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)

23. Signature Alfred G. ... (M.D. or other) 4

Address Deputy ... Date signed 12.16.39

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.....

Warner A. Carver

Licensed Embalmer No.....

3534

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, above space should be left blank.