

Registration District No. 701 Primary Registration District No. 2

1. PLACE OF DEATH: 1003
(a) County St Louis
(b) City or town St Louis
(c) Name of hospital or institution 3003 McNAIR
(d) Length of stay: In hospital or institution 14 mo.
In this community 14 mo. years, months or days

3. (a) PRINT FULL NAME AMELIA COLLENG 45
(b) If veteran, name war
(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 Otto Coleng
6. (c) Age of husband or wife if alive 7 years
7. Birth date of deceased 8 Jan 7 1862 (Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 10 If less than one day hr. min.

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

10. Usual occupation House wife 6

11. Industry or business Home

12. Name UNKNOWN KAILES 6

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

14. Maiden name AMELIA UNKNOWN

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

16. (a) Informant's own signature Charles Coleng

(b) Address Fort Bliss Texas

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

(c) Place: burial or cremation El Reno OKLA

18. (a) Signature of funeral director W. J. May & Co.

(b) Address 9929 S. Johnson

19. (a) DEC 18 1939 (b) Registrar's signature

(Date of local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State MO (b) County
(c) City or town St Louis 24
(d) Street No. 3003 McNAIR
(e) If foreign born, how long in U. S. A? 68 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 17
year 1939 hour 1 minute P. M.
21. I hereby certify that I attended the deceased from Dec 8.
1939 to Dec 17 1939
that I last saw her alive on Dec 17 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
- arteriosclerosis (chronic
cardio-vascular - renal syndrome)
Duration 5 years

Due to
Due to
Other conditions c
(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) (e) Means of injury
28. Signature Wm J. Hotter (M. D. or other)
Address 1040 Summit Date signed 12/18/39

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.

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.....

Paul A. Shanklin

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Paul A. Shanklin

Licensed Embalmer No. *3472*

P. O. Address *2929 S. Jefferson*

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

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