

Registration District No. 110

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: 11003  
(a) County St. Louis Mo  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: 3676a Dover Pl  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 33 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3676a Dover Pl  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Arthur Sauter 360  
8. (b) If veteran, name war None  
8. (c) Social Security No. 489-10-7734

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 6  
year 1940 hour 10 minute 40 AM

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lillian Sauter 6. (c) Age of husband or wife if alive 43 years  
7. Birth date of deceased July 31 1882  
(Month) (Day) (Year)

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.

8. AGE: Years Months Days If less than one day  
57 5 6 hr. min.

Immediate cause of death  
arteriosclerosis  
metastatic carcinoma  
of the testis  
(Other conditions (include pregnancy within 3 months of death))

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

10. Usual occupation Office Manager

11. Industry or business Loose Wiles Biscuit Co

MOTHER FATHER  
12. Name Jacob Sauter  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Wilhemina Sheer  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs Lillian Sauter  
(b) Address 6376a Dover Pl

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 1 9 40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sunset Burial Pk

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Kriegshauser Und Co  
(b) Address 4228 So. Kinghighway Blvd  
19. (a) Jan 6 40 (b) J.P. [Signature]  
(Date received local registrar) (Signature of registrar)

23. Signature [Signature] (M.D. or other)  
Address Deputy [Signature] Date dictated \_\_\_\_\_

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.....

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

working under my personal supervision.

Signed

*Reinhold K. Lohman*

Licensed Embalmer No.

*3395*

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.**

*Chapman*