

Registration District No. 797Primary Registration District No. 1003

## 1. PLACE OF DEATH:

- (a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Anthony Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Mary Ewers

8. (b) If veteran, name war None  
 8. (c) Social Security No. None

4. Sex Female  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Joseph Ewers  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
67  
 7. Birth date of deceased January 12, 1878  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 1 5 \_\_\_\_\_  
 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housework11. Industry or business At Home

- MOTHER FATHER  
 12. Name Martin Rinie  
 13. Birthplace Germany  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Hassenfratz  
 15. Birthplace Germany  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph Ewers  
(b) Address 4009a McRee Avenue17. (a) Burial (b) Date thereof Feb. 21, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Old S. S. Peter & Paul Cem.18. (a) Signature of funeral director Wm. Robert  
(b) Address 1905 So. Grand Blvd.19. (a) FEB 20 1940 (b) \_\_\_\_\_  
(Date received local registrar)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 18  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4009a McRee Avenue  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17  
 year 1940 hour 9:50 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from  
Feb. 12, 1940 to Feb. 17, 1940  
 that I last saw her alive on Feb. 17, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Pneumococcus meningitidis</u>	<u>2 days</u>
<u>Pneumococcus bacteremia</u>	<u>2 "</u>
Due to <u>Tubercular Pneumonia type 8</u>	<u>2 "</u>
Due to _____	_____

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
Sciatic neuritis 5 days.  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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 \_\_\_\_\_

23. Signature Wm. P. Gunt (M. D. or other) \_\_\_\_\_  
 Address 2227 S. Broadway Date signed 2-19-40

**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 W. J. Robert  
Licensed Embalmer No. 502  
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.**