

S. No. 2
-11-10-39
-5-17-39
-1-1-42

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16868**
Registrar's No. **4346**

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days) 430

3. (a) PRINT FULL NAME Caroline Augusta Sewald
(b) If veteran, name war No.
(c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Antone
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 22 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 21 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Christian Miller
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Charlotte Long
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. I. Aubuchon
(b) Address Bonne Terre, Mo.

17. (a) Removal (b) Date thereof 5-15-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation French Village, Mo.

18. (a) Signature of funeral director Albert H. Hoppe.

(b) Address 4700 Washington Ave.

19. (a) MAY 15 1940 (b) J. F. Bredet
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ste. Genevieve
(c) City or town Festus
(If outside city or town limit write "RURAL") NR
(d) Street No. R. R. #1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 13 year 1940 hour 11 minute _____ M.
21. I hereby certify that I attended the deceased from May 11, 1940, to May 17, 1940, that I last saw her alive on May 13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: ventricular fibrillation following apoplexy for T. B.
Due to: myocardial Path
Due to: arteriosclerosis
Other conditions: Ch. Infected of T. B. with abscess
Major findings: Ball stone abscess
Of operations: none
Of autopsy: none

Duration
many
year
year
year
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 no
(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? no

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

23. Signature J. F. Bredet (M. D. or other)
Address 408 Chestnut Date signed 5/15/40

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

J. G. Sullivan

Licensed Embalmer No. *1122*

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.