

JUN 15 1940 791

Registration District No.

Primary Registration District No.

Registrar's No. **4468**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
In this community Unknown
years, months or days

3. (a) PRINT FULL NAME Margretha Baehler **460**

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Not known 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased January 10, 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 4 7 hr. min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name John Schneider

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

14. Maiden name Gertrude Heintz

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

16. (a) Informant Mrs Cecil Hoppie

(b) Address 2916 Glasgow Ave

17. (a) Burial (b) Date thereof 5/20/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) MAY 20 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis **20**
(If outside city or town limits, write "RURAL")
(d) Street No. 2617 Baldwin St.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17th
year 1940 hour 2:30 PM minute _____ M.

21. I hereby certify that I attended the deceased from 5-5, 1940, to 5-17-40, 1940;

that I last saw her alive on 5-17-40, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cardiac Failure
congestive + anginal
Type

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature [Signature] (M. D. or other MD)

Address 3053 S. Brown Date signed 5/20/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *William G. Buchholz*

Licensed Embalmer No. *2119*

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.