

Registration District No. **788**

Primary Registration District No. **111**

Registrar's No. **1101**

1. PLACE OF DEATH:

(a) County **St. Louis County**
(b) City or town **Richmond Heights Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Marys Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Weeks**
(Specify whether)

In this community **4 1/2**
years, months or days

3. (a) PRINT FULL NAME **SISTER MARY WALBURGA**

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased **May 19th 1891**
(Month) (Dy) (Year)

8. AGE: Years Months Days If less than one day
49 20 2 hr. min.

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

10. Usual occupation **Sister in Religion**

11. Industry or business _____

12. Name **H. Kahler**

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

14. Maiden name **Lona Libemeller**

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

16. (a) Informant **Mrs Mother Jones**

(b) Address **Mathewson 1100 Belleme Ave**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **July 17 1940**
(Month) (Day) (Year)

(c) Place: burial or cremation **Old St. Peter's Church Cemetery**

18. (a) Signature of funeral director **Walter Beckage**

(b) Address **6536 Clayton Road**

19. (a) **JUN 10 1940** (Date received local registrar) (b) **W. Marymo DPH** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL")
(d) Street No. **1100 Belleme Ave**
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **9**
year **1940** hour **1** minute **55 P. M.**

21. I hereby certify that I attended the deceased from **May 13**, 19**40** to **June 9**, 19**40**
that I last saw her alive on **June 9**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pelvic Peritonitis with fecal fistula and partial intestinal obstruction**
Due to **Infection in Wall of Para-Ovarian cyst.**

Other conditions **Tubo Myeloiditis**
(Include pregnancy within 3 months of death)

Major findings: **Large Para-Ovarian Cyst.**
Of operations _____
Of autopsy **Confirmed above diagnosis.**

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 _____

23. Signature **E. O. Brown** (M. D. or other) **M. D.**
*Address **1325 S. Grand.** Date signed **6/9/40**

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

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 _____

Licensed Embalmer No. 3905

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.