

FILED AUG 5 1940

Registration District No. _____

Primary Registration District No. 101

Registrar's No. 1429

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months 14 days
(Specify whether years, months or days)

In this community 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Lemay
(If outside city or town limits, write "RURAL")

Street No. Reavis Barracks Rd.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 28 years years.

3. (a) PRINT FULL NAME Meta Bodewes 320

(b) If veteran, name war ? (c) Social Security No. ?

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Theodore Bodewes 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased July 11 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

41 0 19 hr. min.

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

10. Usual occupation housewife

11. Industry or business 6

12. Name August Rind

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

14. Maiden name Paulina Schlafski

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

16. (a) Informant Husband Theodore Bodewes

(b) Address Reavis Barracks Rd.

17. (a) Bureau (b) Date thereof 8-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Not Observed

18. (a) Signature of funeral director Trudler M.D. Co.

(b) Address 7420 York Ave

19. (a) JUL 30 1940 (b) M. R. Meyer M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1940 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from 4-16-40
1940 to 7-30-40 1940;
that I last saw her alive on 7-30-40 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death:
Chronic encephalitis with
spastic paralysis of both lower
extremities second month

Due to _____

Due to 8/a

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Cerebral edema

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 _____

(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? _____

707
While at work? _____
(Specify type of place) (e) Means of injury

23. Signature M. A. Spitz (M. D. or other) 1

Address St. Louis County Hospital Date signed 7/30/40

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

26
2
2

MOTHER FATHER

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. _____

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.