

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SEP 25 1940
Registration District No. 791

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town ST. LOUIS

(c) Name of hospital or institution:
4749 MAFFITT AVE 2
(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

3. (a) PRINT FULL NAME PHILIPENA MARTIN h35

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 PETER MARTIN

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUGUST 7 1855
(Month) (Day) (Year)

8. AGE: Years 85 Months 0 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace ST. JACOB ILLINOIS
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name PHILIP WASEM

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

14. Maiden name CHRISTINE FRENGER

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

16. (a) Informant's own signature Miss Louise Martin

(b) Address 4749 Maffitt Ave.

17. (a) BURIAL - Removal (b) Date thereof AUG. 24, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. JACOB, ILLINOIS

18. (a) Signature of funeral director J. M. Schumacher

(b) Address 4834 Natural Bridge

19. (a) AUG 22 1940 (b) _____
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

0

(a) State MISSOURI (b) County _____

(c) City or town ST. LOUIS 6
(If outside city or town limits, write "RURAL")

(d) Street No. 4749 MAFFITT AVE.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21
year 1940 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 31 - 39
_____, 19____, to Aug 21, 1940
that I last saw him alive on Aug 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of
Ball Bladder

Due to _____

Due to _____

Duration
2 months
10
days

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

Major findings:
Of operations _____

Of autopsy _____

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? _____

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

23. Signature Peter A. Eck, M.D. (M. D. or other) _____
Address 4701 St. Louis Ave. Date signed Aug 21 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 John J. Fetter
Licensed Embalmer No. 3880

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.