

Registration District No. **791**

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 2827 Iowa 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 Life.  
years, months or days

8. (a) PRINT FULL NAME BARBARA WESTERMANN **236**

3. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife William Westermann 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 2nd 1870  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>2</u>	<u>24</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business At Home.

MOTHER FATHER { 12. Name John Bartosch

13. Birthplace Bohemia **7**  
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Cuba

15. Birthplace Bohemia **7**  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Koupal  
 (b) Address 2827 Iowa Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/40  
(Month) (Day) (Year)

(c) Place: burial or cremation S. S. Peter & Paul

18. (a) Signature of funeral director Shordutis  
 (b) Address 2906 Gravois Ave.

19. (a) AUG 28 1940 (Date received local registrar) (b) J. B. Budick (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

**1003**  
 (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis. **24**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2827 Iowa 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 26  
 year 1940 hour 7 55 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 1939  
 to August 26 1940  
 that I last saw her alive on August 26th 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Failure **1 day**

Due to Chronic Cardio-Vascular-Renal Disease **1 yr +**

Other conditions None **131**  
(Include pregnancy within 3 months of death)

Major findings: None.

Of operations \_\_\_\_\_

Of autopsy None.

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) Manner of injury \_\_\_\_\_

23. Signature Quintin J. [Signature] (M. D. or other) **8/27/40**  
 Address 3606 Gravois Date signed \_\_\_\_\_

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 \_\_\_\_\_

*Thos Luti*

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed *Thos Luti* \_\_\_\_\_

Licensed Embalmer No. *1619* \_\_\_\_\_

P. O. Address *2906 Garrison* \_\_\_\_\_

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.