

Registration District No. **791** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **18 Days**
(Specify whether In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Ike Wasserkrug**
3. (b) If veteran, name war **No** **3. (c) Social Security No.** **None**

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Divorced**
6. (b) Name of husband or wife **unknown** **6. (c) Age of husband or wife if alive** **unk** years

7. Birth date of deceased **unknown**
(Month) (Day) (Year)

8. AGE: Years **60** Months **—** Days **—** If less than one day **hr.** **—** **min.** **—**

9. Birthplace **Galicia Austria Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman (Formerly)**

11. Industry or business **Drugs**

12. Name **Aaron Wasserkrug**

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

14. Maiden name **Gertrude Nasson**

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

16. (a) Informant **S. H. Wasserkrug**

(b) Address **St. Joseph Missouri**

17. (a) removal **(b) Date thereof** **9-24-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Joseph Missouri**

18. (a) Signature of funeral director **H. E. Berger**
(b) Address **4715 McPherson Ave.,**

19. (a) SEP 24 1940 **(b) J. F. Brudack**
(Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis** **34**
(If outside city or town limits, write "RURAL")
0 **604 Chestnut**
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **23**,
 year **1940** hour **12:00** minute **Noon** M.

21. I hereby certify that I attended the deceased from **September**
6, 19**40**, to **September 23**, 19**40**

that I last saw him alive on **September 23**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral hemorrhage of the lung
(probable)

Due to _____
 Due to _____

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

Major findings:
 Of operations _____

Of autopsy _____

Duration

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? _____ **(e) Means of injury** **1**

23. Signature **H. W. S. Howard** **(M. D. or other)**
Address **1515 Lafayette Ave.,** **Date signed** **9/23/40**

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.....



Licensed Embalmer No.....

1597

P. O. Address.....

4715 McPherson

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, fact should be so stated above.