

NOV 16 1940

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **8684**

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

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 Lutheran Hospital
(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 Charles R. Ehlers

3. (b) If veteran, name war None

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha Stone Ehlers

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased March 16th 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>7</u>	<u>4</u>	_____ hr. _____ min.

9. Birthplace Schleswig-Holstein
(City, town, or county) (State or foreign country)

10. Usual occupation Meat Cutter for self

11. Industry or business _____

12. Name Unknown Ehlers

13. Birthplace Schleswig-Holstein
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Schleswig-Holstein
(City, town, or county) (State or foreign country)

16. (a) Informant Bertha Ehlers

(b) Address 6065 Wanda Ave.

17. (a) Burial (b) Date thereof 10-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuar

(b) Address 4228 So. Kingshighway Blvd.

19. (a) OCT 21 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 6065 Wanda Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20th
year 1940 hour 4:15 minute P.M. M.

21. I hereby certify that I attended the deceased from 10-14-40
_____, 19____, to 10-20-40, 19____;
that I last saw him alive on 10-20-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Sanguineous ruptured appendix Duration 2 weeks

Due to _____

Due to _____

Other conditions Pulmonary embolus
(Include pregnancy within 3 months of death)

Major findings: Localized peritonitis

Of operations: Surgency of appendix

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? _____

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

23. Signature [Signature] (M. D. or other) (M.D.)

Address 3657 Franklin Square Date signed 10/21/40

NEB.
Dr. Hanser
3651
Jr 4430

AUG 23 1948

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.....
Edwin M. Hansen

Licensed Embalmer No. *3028*

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, fact should be so stated above.