

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 9001

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Dark Lane Memorial 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 MINNIE WEHRLE

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Emil Wehrle 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased March 13 1879  
(Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days 18 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Lenzburg Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name Erdman Kaegel

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

14. Maiden name Mary Saurwein

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

16. (a) Informant Emil Wehrle  
(b) Address 1155 Bayard Avenue

17. (a) Removal (b) Date thereof Nov. 2, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lenzburg Cemetery

18. (a) Signature of funeral director Chas. F. Stuart

(b) Address 1225 Union Blvd.

19. (a) NOV 1 1940 (b) [Signature]  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 12  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1155 Bayard Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30  
year 1940 hour 10 minute 30 PM M.

21. I hereby certify that I attended the deceased from 10-13-40, 19\_\_\_\_, to 10-30-40, 19\_\_\_\_; that I last saw her alive on 10-30-40, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Right cerebral hemorrhage

Due to Aterial hypertension

Due to Chronic interstitial nephritis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations [Signature]

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? EE (Specify type of place) (e) Means of injury ---

23. Signature Dr. J. Smith (M. D. or other)

Address 4 4930 Lindell Date signed 10/31/40

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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Bernard R. J. Strauch  
Licensed Embalmer No. 3500  
P. O. Address 1225 Union, Pa

**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.**