

23 1943 318

1003

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: Christian Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0001  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 5039 Thrush Avenue (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Marie L. Robinson

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 3 None

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

7. Birth date of deceased April 18, 1877  
(Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 23 If less than one day hr. min.

9. Birthplace St. Charles Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Fred W. Johannpeter

13. Birthplace Germany

14. Maiden name Hannah Greve

15. Birthplace Germany

16. (a) Informant Mrs. Caroline Ellis

(b) Address 3511a Miami Street

17. (a) Burial (b) Date thereof 4/14/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Math. Hermann & Son

(b) Address 2161 East Fair Avenue

19. (a) APR 12 1943 (b) J. F. Medeck  
(Date received local notification) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11 year 1943 hour 6:45 P M minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Oct. 9, 1937, 1943 to April 11, 1943 that I last saw him alive on April 11 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Uterus Duration 5 yrs.

Due to metastatic tumors of

Due to Intestine

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

Major findings: Colostomy for PHYSICIAN \_\_\_\_\_  
Of operations Bowel obstruction due

Of autopsy To Tumor  
no autopsy

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 0

23. Signature Malin G. S. Trechner (M.D. or other)

Address 508 N. Grand Blvd Date signed 4/14/43

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..... *Francis A. Williamson*  
Licensed Embalmer No..... *3565*  
P. O. Address..... *St Louis Mo*

**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.**

Registration District No. 318

Primary Registration District No. 1003

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:  
Christian Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community 35 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Marie L. Robinson

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased: April 18 1908  
(Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 1 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) JUN 19 1948 (b) J. F. Bradeck  
(Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 19 Year 1948  
hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

