

FILED NOV 1 1944

318

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

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  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5536 Maple Ave.  
(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)

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. 5536 Maple Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Laura F. Amrein

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Edmund Amrein 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug. 20 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 2 0 hr. \_\_\_\_\_ min.

9. Birthplace Columbia Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name William T. Carroll  
13. Birthplace Ky.  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Wilson  
15. Birthplace Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Edmund Amrein  
(b) Address 5536 Maple Ave.

17. (a) Burial (b) Date thereof 10-23-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Drehmann-Harral  
(b) Address 1905 Union Blvd.

19. (a) OCT 20 1944 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20  
year 1944 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from 10/1-44, 19\_\_\_\_, to 10/20-44, 19\_\_\_\_;  
that I last saw h. 20 alive on 10/20-44, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction

Due to Arteriosclerosis

Due to Sclerosis Senilis

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

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? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 4932 Maryland Date signed 10/20

Dr. R.K. Andrews (Ro. 4620)  
4932 Maryland Ave.  
1 to 4 Saturday

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**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.....

*Warren A. Carver*

Licensed Embalmer No.....

*3534*

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.**