

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

1. PLACE OF DEATH:

(a) County.....

(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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 4 days
(Specify whether years, months or days)

In this community..... 53 Yrs 4Mons) 0 Days

3. (a) PRINT FULL NAME..... Louise Duepner

3. (b) If veteran, name war..... no

3. (c) Social Security No.....

4. Sex..... Female

5. Color or race..... White

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

6. (c) Age of husband or wife if alive..... 52 years

7. Birth date of deceased..... 9 10 1891
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>53</u>	<u>4</u>	<u>0</u> hr. min.

9. Birthplace..... St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Frank, G. Koehler

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

14. Maiden name..... Rose Herzog

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

16. (a) Informant..... Joseph Duepner

(b) Address..... 4201 Warne Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof..... 1 13 1945
(Month) (Day) (Year)

(c) Place: burial or cremation..... Calvary Cemetery

18. (a) Signature of funeral director..... Goodhart & Goodhart

(b) Address..... 2228 St. Louis Ave

19. (a) JAN 12 1945 (Date received local registrar) (b) J. F. Bredich (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County.....

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

(d) Street No..... 4201 Warne Ave
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Jan day..... 10th
year..... 1945 hour..... 10:55 minute..... A. M.

21. I hereby certify that I attended the deceased from..... 1/6/45
..... 19..... to..... 1/10/45 19.....
that I last saw her..... er..... 1/10/45.....
and that death occurred on the date and hour stated above.

Immediate cause of death..... Hemolytic staphylococcus septicaemia

Due to..... Diabetic gangrene of both feet

Due to.....

Other conditions..... suppurative nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy..... Same

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. Lemay Jr. (Date signed) 1/10/45
Address..... 1515 Lafayette

211
10 17 9

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Majie A. Cashion*
Licensed Embalmer No..... *3949*
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.