

FILED FEB 24 1945

Registration District No. 3/7

Primary Registration District No. 2002

Registrar's No. 420

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7317 Pershing Avenue, 1
(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 Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 7317 Pershing Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Lena Ruth Stueck

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

4. Sex Female 5: Color or race White 6. (a) Single, widowed, married, divorced, Single

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

7. Birth date of deceased December 6, 1865
(Month) (Day) (Year)

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

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

10. Usual occupation None

11. Industry or business At home

MOTHER FATHER { 12. Name John R. Stueck 4
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Johanna ?
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Arthur R. Stueck

(b) Address 7317 Pershing Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/45
(Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) FEB 19 1945 (Date received local registrar) (b) E. M. Gannon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14
year 1945 hour 1 minute 15 P.A.M.

21. I hereby certify that I attended the deceased from Jan. 25, 1945 to 2/11/45, 19____
that I last saw her alive on 2/11/45, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Ch. myocarditis 5 yrs.
Due to Cardio-renal-vascular disease with hypertension 5 yrs.
Due to Acute cholecystitis 3 weeks
Other conditions _____
(Include pregnancy within 3 months of death)

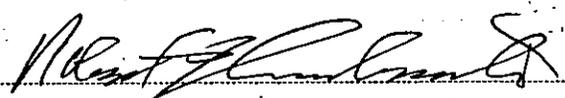
PHYSICIAN _____
Major findings: 1316
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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 Edwin P. Meiners (M. D. or D.O.)
Address 6651 Enright Avenue Date signed 2/15/45

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.....



Licensed Embalmer No.....

1994

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.