

1-8-43
5-17-39
X37823

FILED 11B 23 1945
Registration District No. 3063

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis Co.
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Co. Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7-13-45 to 7-16-45
(Specify whether
In this community 9 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96
(c) City or town 4242 Ravenwood, Pine Lawn 0
(If outside city or town limits, write "RURAL")
(d) Street No. 4242 Ravenwood 0
(If rural, give location)
(e) Citizen of foreign country? Germany (Yes or No)
If yes, name country Germany

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 16
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Due to Complication from fracture femur
Due to Hypertensive Cardiovascular disease

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME BOTT, TILLIE

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

4. Sex Female 0 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife August Bott 6. (c) Age of husband or wife if alive see years

7. Birth date of deceased: 4 (Month) 16 (Day) 93 (Year)

8. AGE: Years 72 Months 3 Days no If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business none

12. Name J. Japps

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

14. Maiden name Mary Anna Japps

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

16. (a) Informant Anna Oberschelp - daughter

(b) Address 4242 Ravenwood, Pine Lawn

17. (a) Burial (b) Date thereof 7-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director Hy. Leidner Und. Co

(b) Address 2223 St. Louis Ave.

19. (a) 7-19-45 (b) E. M. Gauran MD
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following: 96
(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 E. M. Gauran MD (Dr. D. or other)
Address 601 Bentwood - Clayton Date signed 7-16-45

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

See page 3

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.....

John Fetter

Licensed Embalmer No. 3880

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. 317

Primary Registration District No. 6067

Registrar's No. 1819

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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

Jillie Boff

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 wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Apr 16 1898
(Month) (Day) (Year)

8. AGE: Years 72 Months _____ Days _____ If less than one day hr. _____ min. _____

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (Date received local registrar) (b) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 1945 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 1945;

that I last saw him _____ alive on _____, 1945; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Pneumonia fracture Cerebral hemorrhage intervertebral fracture Cerebral hemorrhage

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 7/13/45

(c) Where did injury occur? One Farm S. of St. Louis Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. J. Murphy M. D. or other _____

Address 601 Rutland Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-24597