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36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. **39823**
Registrar's No. **10798**

FILED DEC 21 1945
318

Registration District No. _____ 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:
LUTHERAN HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 WKS.**
(Specify whether
In this community **14 WKS.**
years, months or days)

3. (a) PRINT FULL NAME **PAULA H. SPREHE**
3. (b) If veteran, name war **V**
3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **EDWARD H.**
6. (c) Age of husband or wife if alive **53** years
7. Birth date of deceased **OCT 31 1899**
(Month) (Day) (Year)

8. AGE: Years **46** Months **1** Days **6**
If less than one day hr. _____ min. _____

9. Birthplace **AMHERST WISCONSIN**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business _____

MOTHER FATHER
12. Name **PAUL LEHMANN**
13. Birthplace **NEW WELLS MO.**
(City, town, or county) (State or foreign country)
14. Maiden name **CLARA POHLMANN**
15. Birthplace **LANESVILLE IND.**
(City, town, or county) (State or foreign country)

16. (a) Informant **EDWARD H. SPREHE**
(b) Address **HOFFMAN ILL. ROUTE NO 4**

17. (a) **REMOVAL** (b) Date thereof **12-7-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **CENTRALIA ILL.**

18. (a) Signature of funeral director **BOGGS FUNERAL HOME**
(b) Address **CENTRALIA ILL.**

19. (a) **DEC 21 1945** (Date received for registration)
J. F. Bredeson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **ILLINOIS** (b) County **997**
(c) City or town **HOFFMAN**
(If outside city or town limits, write "RURAL")
(d) Street No. **ROUTE NO 4**
(If rural, give location) **NR.**
(e) Citizen of foreign country? **91** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** 7
year **1945** hour **11** minute **30** A.M.
21. I hereby certify that I attended the deceased from **8/30/45**
to **12/7** 19**45**
that I last saw **her** alive on **12/7** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Adenocarcinoma of
Breast tissue** **bluo**
Due to _____
Due to **HA**
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **Exploratory operation
(as above)**
Of operations _____
Of 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? _____

23. Signature **Wm. H. Hunsaker M.D.**
While at work? _____ (Specify type of place) (e) Means of injury _____
Address **3657 Grand St** Date signed **12/21/45**

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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.....

John Ketter
.....
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.