

FILED JAN 11 1945  
318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

## 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:  
City Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 hrs.  
(Specify whether  
 In this community Life  
years, months or days)

3. (a) PRINT FULL NAME Charles T. Vahlenkamp, Sr.3. (b) If veteran, name war No 3. (c) Social Security No. \_\_\_\_\_4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Kate Vahlenkamp 6. (c) Age of husband or wife alive years \_\_\_\_\_7. Birth date of deceased August 5, 1886  
(Month) (Day) (Year)8. AGE: Years 59 Months 4 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Private Watchman11. Industry or business St. Louis Independent Packing12. Name Fred Vahlenkamp13. Birthplace Unknown  
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown  
(City, town, or county) (State or foreign country)16. (a) Informant Charles J. Vahlenkamp(b) Address 3724 Lawler Dr. Pine Lawn17. (a) Burial (b) Date thereof Dec. 28, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Johns Cemetery18. (a) Signature of funeral director Calvin F. Feutz Funeral Home (Specify type of place) \_\_\_\_\_  
 (b) Address 4828 Natural Bridge Blvd. (c) Means of injury \_\_\_\_\_19. (a) DEC 27 1945 J. F. Breneak  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4565 Gibson Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26th  
 year 1945 hour 12:10 minute A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Cerebral Apoplexy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
 (e) Means of injury \_\_\_\_\_23. Signature John E. Sullivan (M.D. or other) \_\_\_\_\_Address alg Date signed 12/27/45

**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 *John A. Miller*

Licensed Embalmer No. *4186*

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.**