

FILED MAR 30 1946
318

Registration District No. _____

Primary Registration District No. **1003**Registrar's No. **2651**

1. PLACE OF DEATH:

(a) County **St. Louis Mo**
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4336 Arsenal St
 (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 **Ida Buchheit**3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**4. Sex **Female** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**6. (b) Name of husband or wife **Jacob** 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased **Oct 11 1883**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
62 5 7 hr. min.9. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)10. Usual occupation **Housework at Home**

11. Industry or business _____

12. Name **John Meier**13. Birthplace **Switzerland**
(City, town, or county) (State or foreign country)14. Maiden name **Anna Ermeling**15. Birthplace **Germany**
(City, town, or county) (State or foreign country)16. (a) Informant **Jacob Buchheit**(b) Address **4336 Arsenal St**17. (a) **Burial** (b) Date thereof **3 21 46**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **St. Johns Cemetery**18. (a) Signature of funeral director **Kriegshauser**(b) Address **4228 So. Kingshighway**19. (a) **MAR 20 1946** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **000**
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL") **17**
 (d) Street No. **4336 Arsenal St** **16**
 (If rural, give location) **9**
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **18**
year **1946** hour **6.30** PM minute _____ M.21. I hereby certify that I attended the deceased from **Sept 6 1945** to **3-18-46**
that I last saw her alive on **3-18-46** and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic myocardial

Due to _____

Due to **Carcinoma of Liver & Gall Bladder**Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: **2 one**
Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
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) **2 one**

(b) Date of occurrence _____

(c) Where did injury occur? **2 one**
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
2 oneWhile at work? _____ (Specify type of place) (e) Means of injury **2 one**23. Signature **Dr. F. Harman** (M. D. or other) **20**Address **2739 28th** Date signed _____

Dr M F Harmann

2739 No. Grand

2-4

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... *Edwin D Mc Dermott*

Licensed Embalmer No. *3024*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 2651

Registration District No. 319

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:

(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..... Ida. Buchheit

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..... m

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

7. Birth date of deceased..... Oct (Month) 11 (Day) 1896 (Year)

8. AGE: Years 62 Months Days If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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..... 18 year..... 1946 hour..... minute.....

21. I hereby certify that I attended the deceased from 3-18-46 to 3-18-46, 1946 that I had seen her alive on 3-18-46 and that death occurred on the date and hour stated above.
Immediate cause of death..... chronic myocarditis

Due to.....

Due to..... Additional
Parasitosis of liver
and gall bladder
Other condition (Include pregnancy within 3 months of death).....
NO OTHER

Major findings: Of operations..... none

Of autopsy..... no

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

(a) Accident, suicide, or homicide (specify)..... no

(b) Date of occurrence.....

(c) Where did injury occur?..... no (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
no injury

While at work?..... (Specify type of place) (Type of means of injury) no

23. Signature..... Dr. J. H. Hargrave (M. D. or other)

Address..... 2739 N. Grand Date signed..... 3-18-46

SUPPLEMENTARY

WHILE FILLING IN USE SPARING BLACK INK - MAKE A PERMANENT RECORD

2/86

10963