

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Irma Disbrow**

3. (b) If veteran, name war **--**

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 **Herbert**

6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **May 27 1891**
(Month) (Day) (Year)

8. AGE: Years **54** Months **11** Days **3** If less than one day _____ hr. _____ min.

9. Birthplace **Sheboygan Wisconsin**
(City, town, or county) (State or foreign country/)

10. Usual occupation **Housewife**

MOTHER FATHER

11. Industry or business _____

12. Name **George A. Schraut**

13. Birthplace **Sheboygan Wisconsin**
(City, town, or county) (State or foreign country/)

14. Maiden name **Unknown**

15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country/)

16. (a) Informant **Herbert Disbrow**

(b) Address **2608 Louisiana**

17. (a) **Cremation** (b) Date thereof **5/2/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mo. Crematory**

18. (a) Signature of funeral director **Wacker-Heldens**

(b) Address **3634 Grayoia Ave.**

19. (a) **MAY 1 1946** (Date of local registration)

J. F. Bredack (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **17/7**

(d) Street No. **2608 Louisiana**
(If rural, give location) **90**

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **30**
year **1946** hour **12** minute **12 A** M.

21. I hereby certify that I attended the deceased from **Apr 27** 19____ to **Apr 30** 19____
that I last saw him/her alive on **Apr 30** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cancer of sigmoid**

Due to _____

Due to _____

Other conditions: **None**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
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 **R. Berg** (M. D. or other) **13/7/46**
Address **2234 Hubbard** Date signed

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 Robert Wheeler.....

Licensed Embalmer No. 2128.....

P. O. Address St. Louis.....

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.