

**FILED** APR 10 1946

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

Registrar's No. **3326**

**1. PLACE OF DEATH:**  
 (a) County St. Louis, Missouri  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial  
(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)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County oao  
 (c) City or town St. Louis 24/17  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3926 Pennsylvania  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_  
(Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** JULIUS GUEHRING  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased June 17 1876  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month April day 9th  
 year 1946 hour 5:45 minute \_\_\_\_\_ A \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from 4/6/46  
 \_\_\_\_\_, 19\_\_\_\_, to 4/9/46, 19\_\_\_\_;  
 that I last saw h. im alive on 4/9/46, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>9</u>	<u>22</u>	hr. _____ min. _____

Immediate cause of death Intra-cranial Hemorrhage  
 Due to No injury.  
 Due to \_\_\_\_\_

9. Birthplace St. Louis County Mo  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Retired Farmer  
 11. Industry or business \_\_\_\_\_

Other conditions Jaundice  
(Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
 12. Name Henry Guehring  
 13. Birthplace St. Louis Couty Mo  
(City, town, or county) (State or foreign country)  
 14. Maiden name Ellen Mueller  
 15. Birthplace St. Louis County Mo  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Mrs Joseph Eisele  
 (b) Address 3926 Pennsylvania  
 17. (a) Burial (b) Date thereof 4/11/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? No

(c) Place: burial or cremation St John Cem Mehlville  
 18. (a) Signature of funeral director Wm Schumacher  
 (b) Address 3013 Meramec st  
 19. (a) APR 10 1946 (b) J. F. Bressack  
(Date received from registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (a) Means of injury  
 23. Signature W. M. J. G. [unclear]  
1515 Lafayette 4/9/46  
(or other)  
 Address \_\_\_\_\_ 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 Francis Williamson

Licensed Embalmer No. 3565

P. O. Address St. Louis Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

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.....  
  
In this community.....  
years, months or days) (Specify whether

3. (a) PRINT FULL NAME

Julius Gehring  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex male 5. Color of w race.....  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Day.....  
if less than one day  
hr. min.

9. Birthplace.....  
(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.....

13. (a) Signature of funeral director.....  
(b) Address.....

19. (a) (Date received local registrar)..... (b) J. J. Bredeck  
(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 11 1946  
year..... hour..... minute..... M.  
21. I hereby certify that I attended the deceased from.....  
to..... 19.....  
that I last saw h..... alive on.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....  
Due to.....  
Other conditions.....  
(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..... (M. D. or other).....  
Address..... Date signed.....

SUPPLEMENTARY

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

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