

U.S. No. 2
OM-5-43
REV. 5-17-39
I X36671

FILED 3/14/46

Registration District No. **3144** Primary Registration District No. **6076 1003** Registrar's No. **1168**

1. PLACE OF DEATH: **St. Louis**

(a) County **St. Louis**

(b) City or town **Jennings**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **Elms Convalescent Home**
2520 Mc Laren Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **About 55 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis** **96**

(c) City or town **Jennings**
(If outside city or town limits, write "RURAL") **NR**

(d) Street No. **2520 Mc. Laren Av.**
(If rural, give location)

(e) Citizen of foreign country? **Not Known** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Karl Gottwald**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **About 80 years old.**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **15**
year **1946** hour **41** minute **30** A.M.

21. I hereby certify that I attended the deceased from **August 10**
1942 to **May 15** 19**46**
that I last saw him alive on **May 14** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** **12 yrs?**

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

About 80 **Unknown** hr. _____ min. _____

9. Birthplace **Unknown** **Germany** **4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farm Labor**

Due to **93-d.**

Due to _____

Other conditions **Arteriosclerosis** **15 yrs?**
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**

13. Birthplace **Germany ?** **4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Germany ?** **4**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. E. Cummings**
(b) Address **2520 Mc. Laren Av.**

17. (a) **Removed Anatomical Board** (b) Date thereof **5-15-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington**

18. (a) Signature of funeral director **W. Richter**
(b) Address **355 - 1/2 - 1/2 - 1/2**

19. (a) **MAY 20 1946**
(Date received by registrar) (Month) (Day) (Year)

PHYSICIAN

Major findings:
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 **Genevieve L. Arnold** (M. D. or other) **MD**
While at work? _____ (Specify type of place) (c) Means of injury _____
449 Mc Laren Date signed **5/15/46**

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

169920

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.....

.....
Licensed Embalmer No.....

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.