

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7770**

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:  
2610 Chippewa 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 Josephine Combrevis

3. (b) If veteran, name war..... No  
 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married /  
 6. (b) Name of husband or wife Olinto Combrevis  
 6. (c) Age of husband or wife if alive 70 years  
 7. Birth date of deceased 6/7/1874  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>3</u>	<u>0</u>	.....hr. ....min.

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

10. Usual occupation At Home

11. Industry or business Housewife

12. Name Peter Ducarmont

13. Birthplace France  
(City, town, or county) (State or foreign country)

14. Maiden name Margariete Ferrenbach

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

16. (a) Informant Olinto Combravis

(b) Address 2610 Chippewa St

17. (a) Burial (b) Date thereof 9/11/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter & Pauls

18. (a) Signature of funeral director Robert J. Ambruster Inc

(b) Address 6633 Clayton Road

19. (a) SEP 9 1946 (b) J.F. Bredeck  
(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. 2610 Chippewa St  
(If rural, give location)  
 (e) Citizen of foreign country?.....  
(Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 7th,  
 year 1946 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from  
9/5/46, 19... to 9/7/46, 19...;  
 that I last saw her alive on 9/5/46, 19...  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Chronic myocarditis

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations No operation

Of autopsy No 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?

While at work?.....  
(Specify type of place) (e) Means of injury.....

23. Signature C. Kuntz (M. D. or other) X  
 Address 2800a Chippewa Street Date signed 9/8/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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 Arnold W. Schoene  
Licensed Embalmer No. 3864  
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.**