

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36571

FILED OCT 16 1946
Registration District No. 318

Primary Registration District No.

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

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:
City Infirmiry Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1-5-46 to
In this community 10-5-46
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bar
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 1717
(d) Street No. 5800 Arsenal St.
2636 Minnesota Ave
(If outside city or town limits, write "RURAL" and location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Catherine Messmer

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 widow

6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased Aug. 10 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>1</u>	<u>25</u>	<u>4</u> hr. <u>4</u> min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business.....

12. Name unk.

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

14. Maiden name unk.

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

16. (a) Informant Infirmiry Records

(b) Address 5800 Arsenal St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 9-1946
(Month) (Day) (Year)

(c) Place: burial or cremation OLD SS. PETER & PAUL

18. (a) Signature of funeral director Thos. Woods & Son

(b) Address 2906 Harris St.

19. (a) OCT 7 1946 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEP day 10 year 1946 hour 10:45 p.m. minute..... M.

21. I hereby certify that I attended the deceased from Oct-1-5-46 to 10-5-46 that I last saw her or alive on 10-5-46 and that death occurred on the date and hour stated above.

Immediate cause of death Recurrent Cerebral Arterial accident - primary 1945 plus
Due to (2) Emphysema - Long duration

Due to (3) Old Fracture Femur 1945 plus.

Other conditions 8/3/46
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration
PHYSICIAN
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) Means of injury.....

23. Signature Blaise Prunne Bowdich (M. D. or other) Address 5800 ARSENAL Date signed 10/16/46

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..... *David Van Joosen*

Licensed Embalmer No. *4242*

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.