

FILED JAN 7 1947

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11190**

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:
Deaconess Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 day's**
 (Specify whether
 In this community
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **St. Louis**
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **6145 Lindell Blvd.**
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME **Ida S. Alewel**
 (b) If veteran, name war **No**
 (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Frank H. Alewel**
 6. (c) Age of husband or wife if alive **62** years
 7. Birth date of deceased **July 16, 1884**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 **5** **12** hr. min.

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

10. Usual occupation **Housework**

11. Industry or business

12. Name **John H. Vette**
 13. Birthplace **Illinois**
 (City, town, or county) (State or foreign country)

14. Maiden name **Lena Conrad**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Frank H. Alewel**
 (b) Address **6145 Lindell Blvd.**

17. (a) **Burial** (b) Date thereof **Dec. 30, 1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cemetery**
Paschedag-Henke

18. (a) Signature of funeral director
 (b) Address **2825 N. Grand Blvd**

19. (a) **DEC 29 1946** (b) **J. P. Bruns**
 (Date received Seal Applied) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec. 28th**
 year **1946** hour **9** minute **45** A. M.

21. I hereby certify that I attended the deceased from **Dec. 22,**
 19**46** to **Dec. 28,** 19**46**
 that I last saw h **alive** on **Dec. 27,** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart Failure**
Cypho-scoliosis c. Cor Pulmonale
 Duration **10 days.**

Due to
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy
 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?

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

23. Signature **J. P. Bruns** (M. D. or other) **M.D.**
 Address **Humboldt Bldg. St. Louis** Date signed **12/28/46**

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

MOTHER FATHER

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.....

Henry M. Brammer

Licensed Embalmer No.....

4200

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.