

Registration District No. _____ Primary Registration District No. _____

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: St. Johns Hospital **0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 25 days
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Anna Oxmann

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female **5. Color or race** White

6. (a) Single, widowed, married, divorced Widow **2**

6. (b) Name of husband or wife Henry Oxmann

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 5, 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>7</u>	<u>26</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 _____

MOTHER FATHER

12. Name Edward Sexauer

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

14. Maiden name Anna Jenne

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

16. (a) Informant Herman Sexauer

(b) Address 3745 Shreve Ave

17. (a) Burial **(b) Date thereof** 4/3/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany Cemetery

18. (c) Signature of funeral director Math Hermann & Son, Inc
While at work? (Specify type of place)

(b) Address 2161 East Fair Ave

19. (a) APR 2 1947 **(b) J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gas

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4511 Natural Bridge
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 31,
 year 1947 hour 5:30 PM minute _____ M.

21. I hereby certify that I attended the deceased from Feb 11 1947, to Mar 31 1947
 that I last saw her alive on Mar 31 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Primary Carcinoma of Liver **6 wks?**

Due to Chronic Myocarditis **3 yrs**

Due to _____

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

PHYSICIAN

Major findings: Primary Ca of Liver

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? _____

23. Signature B. A. Luedeman (M. D. or other) **MD**

Address 4126 Sher Date signed 4/1/47

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

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 *Walter G. Burnley*
Licensed Embalmer No. *4302*
P. O. Address *W. Burnley*

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.