

FILED MAY 9 1947
Registration District No. **318**

Primary Registration District No. **1003**

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:
5329 Walsh 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5329 Walsh St**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Elsie Bontemps**

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

7. Birth date of deceased **February 28 1889 1889**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 2 2 hr. min.

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

10. Usual occupation **At Home**

11. Industry or business **Paul Fiegel**

MOTHER FATHER

12. Name **Germany** 4

13. Birthplace **Amanda Knop**
(City, town, or county) (State or foreign country)

14. Maiden name **Germany** 4

15. Birthplace **Norma Huber**
(City, town, or county) (State or foreign country)

16. (a) Informant **5329 Walsh St**

(b) Address.....

17. (a) **Cremation** (b) Date thereof **5-3-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Missouri Crematory**

18. (a) Signature of funeral director **Ziegenfuss Bros.**

(b) Address **6409 Crovois Ave**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **30th** day **April**
year **1947** hour **4:15** minute **AM** M.

21. I hereby certify that I attended the deceased from **Feb 2**, 19**47** to **April 30**, 19**47**
that I last saw **her** alive on **April 29**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

hypertension
apoplexy 6 days

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?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature **J. B. Perry** (M. D. or other) **md**

Address **1446 S. Grand** Date signed **5-1-47**

STATE OF OHIO
DEPARTMENT OF HEALTH
BUREAU OF HEALTH

Dr. W. E. Perry
1446 S. Grand Street
Box 7362

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 Fry*

Licensed Embalmer No. *3882*

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.