

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED SEP 24 1948
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 St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

3: (a) PRINT FULL NAME Wilhelmina Aschentrop

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frederick A.

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

7. Birth date of deceased April 10th, 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>5</u>	<u>4</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name John H. Sommerich

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

14. Maiden name Minnie Wehmuller

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

16. (a) Informant Clara Aschentrop (Daughter)

(b) Address 4559 Durant Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 9/16/48
(Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Kraeger-Voss, Inc.

(b) Address 3402 N. Kingshighway

19. (a) SEP 14 1948
(Date received local registrar)

J. F. Bruce
(Registrar's signature)

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. 4559 Durant Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 14th
year 1948 hour 45 minute A M.

21. I hereby certify that I attended the deceased from Sept 9th
1948 to Sept. 14, 1948;
that I last saw her alive on Sept. 14, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Gastro-intestinal hemorrhage

Duration 2 hrs
6 days

Due to Carcinoma of stomach
4 yrs

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy Carcinoma of stomach
celebrating with hemorrhage

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 1

23. Signature J. F. Bruce (M. D. or other) M.D.
Address 4452 Marquette Ave. Date signed 9/16/48

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 W. W. Wilkins
Licensed Embalmer No. 3575
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.