

FILED SEP 13 1951

STANDARD CERTIFICATE OF DEATH

State File No. 28007
7789

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Mo. b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) 5135 Wabada Ave. 0	

3. NAME OF DECEASED (Type or Print)	a. (First) Charles	b. (Middle) Ernst	c. (Last) Ahrens	4. DATE OF DEATH (Month) (Day) (Year) Aug. 31 1951
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5. SEX 0 male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed ✓	8. DATE OF BIRTH Oct. 21 1871 1 79	9. AGE (In years last birthday) Months Days 1 79	IF UNDER 1 YEAR Hours IF UNDER 2 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ice & Coal Dealer	10b. KIND OF BUSINESS OR INDUSTRY For self	11. BIRTHPLACE (State or foreign country) Germany 4	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Ella M. Ahrens
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Thomas Ahrens, 5135 Wabada Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac Decompensation DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4500
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall
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22. I hereby certify that I attended the deceased from Aug 28, 1951, to Aug 31, 1951, that I last saw the deceased alive on Aug 31, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.

23a. SIGNATURE John J. Shaner M.D.	(Degree or title)	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 9-1-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial 0	24b. DATE 9/4/51	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL REG. SEP 4 1951	REGISTRAR'S SIGNATURE E. L. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral	ADDRESS 1905 Union Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2009

1951 W. 25

Dr. John F. Shaner,
Beumont Bldg.,

(1 to 3)

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Warren A. Carver.....

Licensed Embalmer No. 3574.....

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.