

FILED OCT 3 1944
Registration District No. 317

Primary Registration District No. 6076

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Normandy
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Sullivan Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 months
(Specify whether
in this community _____
years, months or days)

3. (a) PRINT FULL NAME Minnie H Wolters
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: October 29 1868
(Month) (Day) (Year)

| | | | | |
|---------|-----------|-----------|----------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | <u>75</u> | <u>11</u> | <u>4</u> | hr. _____ min. |

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER

12. Name William Wolters
13. Birthplace Germany U
(City, town, or county) (State or foreign country)
14. Maiden name Fredericks Bennholz
15. Birthplace Germany U
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs George Engelke
(b) Address 2528 North 21st Street

17. (a) Burial (b) Date thereof Oct 5 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Peters

18. (a) Signature of funeral director Beiderwieden Fun'l Home
(b) Address 1936 St. Louis Avenue

19. (a) OCT 5 1944 (b) S. H. Madrasan, M.D.
(Date received final report) (Registrar's signature) ms

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis 96
(c) City or town Normandy 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. O'Sullivan Nursing Home
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3
year 1944 hour 7 minute 30 a.m.
21. I hereby certify that I attended the deceased from Jan
19 Feb to Oct 3 19 44
that I last saw her alive on Oct 2 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death: Conary Thrombi
Heart Collapse
Pulmonary Embolism
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

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 Dr. S. H. Madrasan (M. D. or other) _____
Address 73 W. Belmont Rd. Date signed Oct 5 1944

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..... *Felix J. Krispini*
Licensed Embalmer No..... *3497*
P. O. Address..... *1936 St. Louis*

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.