

FILED MAR 16 1945

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5917 Washington
(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)

3. (a) PRINT FULL NAME Benjamin L. Wolfort

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 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 Unknown
(Month) (Day) (Year)

8. AGE: Years About 65 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Mens Wear

12. Name Henry Wolfort

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

14. Maiden name Hanna Waterman

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

16. (a) Informant Leo Wolfort

(b) Address 6110 Washington

17. (a) Burial (b) Date thereof 3-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cem.

18. (a) Signature of funeral director H. Rindstrop

(b) Address 5216 Delmar

19. (a) MAR 7 1945 (Date received by registrar) J. F. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 5917 Washington (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th
year 1945 hour 4 minute 30 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis
Arteriosclerosis

Due to _____
Due to _____

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

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? _____

(Specify type of place)
While at work? _____ (c) Means of injury _____
23. Signature John E. Taylor (M.D. or other) _____
Address New Can Date signed 3/7/45

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

MOTHER FATHER

100
17
97

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..... *Herman Lindhoff*
Licensed Embalmer No..... *No Embalming*
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.