

FILED DEC 3 1943
 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 _____
 (c) Name of hospital or institution: **4259 Connecticut St.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community **Life** | (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Caroline M. Wessels**
 3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife **No.** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Nov. 24 1886**
 (Month) (Day) (Year)

8. AGE: Years **76** Months **11** Days **33** If less than one day _____ hr. _____ min.

9. Birthplace **Sf. Route No.** (City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business **House Work**

MOTHER FATHER
 12. Name **George Wessels**
 13. Birthplace **Germany** (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Kroeger**
 15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **Agnes Troeber**
 (b) Address **4259 Connecticut**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11 - 30 - 43** (Month) (Day) (Year)

(c) Place: burial or cremation **S. S. Peter & Paul Cem.**
 18. (a) Signature of funeral director **Wm. Hermann**
 (b) Address **3819 S. Grand St.**
 19. (a) **NOV 19 1943** (Date received local registrar) (b) **J. J. Bredsch** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) City **St. Louis**
 (c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
 (d) Street No. **4259 Connecticut** (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country **No.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **17** year **1943** hour **10 30** minute **P.M.** M.
 21. I hereby certify that I attended the deceased from **Nov 15** to **Nov 17** 19**43** that I last saw her alive on **Nov 15** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy**
 Due to **Arteriosclerosis** 7 yrs
Bed ridden for 7 yrs.
 Due to **Myocarditis chronic** 7 yrs
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____

Duration **5 days**
 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?
 23. Signature **Walter P. Evans** (Specify type of place) (e) Means of injury _____
 Address **3146 Morganford** (M. D. or other) Date signed **11-18-43**

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. Wilkinson

Licensed Embalmer No..... *3575*

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.