

Registration District No. **318**

Primary Registration District, No. **1003**

State File No.
Registrar's No. **1102**

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;
6238 Westminister Place /
(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 **Anna F. Sudholt**

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 **Widow**

6. (b) Name of husband or wife **Fred A. Sudholt** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **October 2, 1863**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	4	0	hr. min.

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

10. Usual occupation **Housework**

11. Industry or business.....

MOTHER FATHER { 12. Name **Wm. Brickenkamp**
13. Birthplace **Germany**
(State or foreign country)
14. Maiden name **Anna Stuerler**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ruth Porter**
(b) Address **7218 Westmorland**

17. (a) **Burial** (b) Date thereof **Feb. 5, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove Mausoleum**

18. (a) Signature of funeral director **Paschedag-Henke Fun Home**
(b) Address **2825 N. Grand Blvd.**

19. (a) **FEB 3 1944** (b) **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **6238 Westminister Place**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **2nd**
year **1944** hour **9** minute **35** P.M.

21. I hereby certify that I attended the deceased from **Feb 1st**
19 **44** to **Feb 2** 19 **44**
that I last saw **her** alive on **Feb 2** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis**

Due to **Thrombosis of cerebral arteries**

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration
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?

Home (Specify type of place)
While at work? (e) Means of injury.....
23. Signature **L. W. [Signature]** (M. D. or other)
Address **203 [Signature]** (M.D. or other) **1/31/44**

APR 25 1945

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. 3570

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.