

FILED NOV 20 1944
Registration District No. 317

State File No. _____
Registrar's No. 2302

Primary Registration District No. 3069

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 1-week (Specify whether
In this community 42 Years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Carrie Cleckler Holtgrewe
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced W.
6. (b) Name of husband or wife Emil F. Holtgrewe 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 2nd., 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 6 If less than one day hr. _____ min. _____

9. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name John G. Cleckler
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Jane Purdy
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Kenneth G. Holtgrewe
(b) Address 1350 Charleston Ave.

17. (a) Burial (b) Date thereof 11-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arthur Bonnell

18. (a) Signature of funeral director Arthur Bonnell
(b) Address 5340 Lindell Blvd.

19. (a) NOV 11 1944 (b) E. J. Holleran
(Date received local authority) (Registrar's signature) Address 4452 Maryland Date signed 11-9-44

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County LOD
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4501 Maryland Ave. 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8th.
year 1944 hour 1 minute 50 P. M.

21. I hereby certify that I attended the deceased from Nov 1 44
Nov 8 44 to Nov 8 44
that I last saw him W alive on _____ 19. _____
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis Duration 1 week
anuria 15 1 week
cardiac failure 10 days
Other conditions Chronic cardiac irregular renal bronchitis
distress

Major findings: Of operations _____
Of autopsy above microscopic not performed
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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 _____
Signature Arthur Bonnell (M. D. or other) _____
Address 4452 Maryland Date signed 11-9-44

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Hindell

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.