

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3665

State File No. _____

FILED JAN 10 1945
Registration District No. 377

Primary Registration District No. 3063

Registrar's No. 8656

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days) 58 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Fenton
(If outside city or town limits, write "RURAL") 0
(d) Street No. Box 31
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rudolph Widman, Dr.

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Frieda K. Widman 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased July 24 1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation Dentist

11. Industry or business own office

12. Name Otto Widman

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

14. Maiden name AUGUSTA BENDER

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

16. (a) Informant St. Louis County Hospital

(b) Address 601 Brentwood Blvd. Clayton

17. (a) BURIAL (b) Date thereof DEC. 18 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK HILL CEMETERY

18. (a) Signature of funeral director: Parker Lund co

(b) Address WEBSTER GROVES Mo.

19. (a) DEC 19 1944 (b) E. H. McLawson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 16th
year 1944 hour one minute 10 a. M.

21. I hereby certify that I attended the deceased from Dec. 6, 1944, to Dec. 16, 1944.

that I last saw him alive on Dec. 16, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive - Arteriosclerotic Cardio-vascular Disease & Cardiac Decompensation

Due to _____

Due to _____

Other conditions (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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

Signature Morris Oley (M. D. or other) _____
Address _____ Date signed 12-16-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Leslie Welch....., Registered Apprentice No. *362*
working under my personal supervision.

Signed *E. C. Aldrich*.....

Licensed Embalmer No. *1332*.....

P. O. Address *Walton Groves Mo*.....

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.