

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 790

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)  
 (d) Length of stay: In hospital or institution 6-hours  
(Specify whether

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County 0011  
 (c) City or town St. Louis.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4445 Lindell Blvd.  
(If rural, give location)  
 (e) Citizen of foreign country? 1 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bertha A. Wahl  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month March day 27  
 year 1945 hour 4 minute 25 A.M.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from July 1942  
 \_\_\_\_\_, 19\_\_\_\_, to March 26, 1945;  
 that I last saw her alive on March 26, 1945  
 and that death occurred on the date and hour stated above.

7. Birth date of deceased August 5th., 1865  
(Month) (Day) (Year)

Immediate cause of death cerebral hemorrhage Duration 10 hours

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>6</u>	<u>22</u>	hr. _____ min. _____

Due to hypertension 5-6 yrs

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

Due to \_\_\_\_\_

10. Usual occupation At Home

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

12. Name John Wahl

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

14. Maiden name Elizabeth A. Brown

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

16. (a) Informant Mr. John Wahl

(b) Address 4445 Lindell Blvd.

17. (a) Burial (b) Date thereof 3-29-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine.

18. (a) Signature of funeral director Arthur J. Donnelly  
3840 Lindell Blvd

(b) Address \_\_\_\_\_  
 19. (a) MAR 29 1945 (b) Dr. E. J. McHannan  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

23. Signature Fred Kramer (M. D. or other) MD  
 Address 634 N Grand Date signed 3-27-45

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

16  
8  
3

MAY 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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

**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.**