

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1670

1. PLACE OF DEATH:

(a) County St. Louis

(b) City, town, or village Jennings  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Halls Ferry Memorial Sanitarium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Jennings  
(If outside city or town limits, write "RURAL")

(d) Street No. Halla Ferry and Kappel  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Minnie Wind

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife August Wind

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 19th 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>8</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation at home

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

12. Name Herman Schlueter

13. Birthplace Not known Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Tillie Schowalter

(b) Address 6105a Dewey

17. (a) burial (b) Date thereof 7/2/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem

18. (a) Signature of funeral directors J L Ziegenhein & Sons

(b) Address 7027 Gravois

19. (a) JUL 7 1945 (b) D. N. E. McKeon  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 29  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from April 10 to June 29 1945  
that I last saw him alive on June 29 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Right side of Fore Head  
Duration \_\_\_\_\_  
Carcinoma

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

Due to \_\_\_\_\_ 53

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

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

Of autopsy \_\_\_\_\_

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) NO

(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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Tillie Schowalter (M. D. or other) \_\_\_\_\_  
Address 207 - Clara Bldg Date signed 6-29-45

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

MOTHER FATHER

**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..... *B. P. Kidwell* .....

Licensed Embalmer No. *3877* .....

P. O. Address *7027 Gravois* .....

**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.**