

**FILED** AUG 18 1945

Registration District No.

Primary Registration District No. 3069

Registrar's No. 1219

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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Father Raymond H. Holte

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

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

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

7. Birth date of deceased January 28 1858  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 6 14 hr. min.

9. Birthplace Doenberg, Cologne, Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Priest

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

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown 6  
(City, town, or county) (State or foreign country)

16. (a) Informant Father Erwin  
(b) Address Washington, Mo.

17. (a) Burial (b) Date thereof 8-14-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 7-14-45 (b) R. H. Harand  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 3/6  
(c) City or town Washington 6  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 12  
year 1945 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from 8-8, 1945, to 8-12, 1945  
that I last saw him alive on 8-12, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Carcinoma of Colon  
Due to \_\_\_\_\_ 46 E.

Due to \_\_\_\_\_  
Intense Hypertrophy

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?

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

23. Signature [Signature] (M. D. or Other) \_\_\_\_\_  
Address 634 N. Beach Date signed 8-12-45

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

6  
8

469

**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. Wilkinson  
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.**