

Registration District No. **318**Primary Registration District No. **1003**Registrar's No. **11402**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4506 Alice Ave.
 (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 **Caroline Wehmeyer**

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

4. Sex **Female** / 5. Color or race **White** / 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Frederick J. Wehmeyer** 6. (c) Age of husband or wife if alive **85** years
 7. Birth date of deceased **Jan. 30. 1868**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	10	25	hr. _____ min.

9. Birthplace **St. Louis, Missouri** (City, town, or county) (State or foreign country)10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Frederick Killian**13. Birthplace **Missouri** (City, town, or county) (State or foreign country)14. Maiden name **Louisa Hettel**15. Birthplace **Missouri** (City, town, or county) (State or foreign country)16. (a) Informant **Frederick J. Wehmeyer**(b) Address **4506 Alice Ave.**17. (a) **Burial** (b) Date thereof **12/28/45**
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Calvary**18. (a) Signature of funeral director **[Signature]**(b) Address **2117 E. Grand Blvd.**19. (a) **DEC 27 1945** (b) **J. F. Bredeek**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **4506 Alice Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **25**
 year **1945** hour **9 A.M.** M.

21. I hereby certify that I attended the deceased from **December 5, 1945** to **December 25, 1945**
 that I last saw h. w. alive on **December 25, 1945**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **2 1/2 wks.**

Due to **gen. arteriosclerosis & hypertension** **sp.**

Due to _____
 Other conditions (Include pregnancy within 3 months of death) **83**

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 _____

23. Signature **[Signature]** (M. D. or other) **M.D.**
 Address **2202 University St.** Date signed **12/26/45**

Duration
 2 1/2 wks.
 sp.
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

Rev. Arthur Gundlach,
224 University
O.B. 3995

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.....

Licensed Embalmer No.

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.