

Registration District No. **317**

Primary Registration District No. **6676**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Wellston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute to St. Louis County Hosp.
(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 **Joseph Richter**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife **Ida Felchlin Richter** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **January 29 1980**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	66	10	17	hr. _____ min. _____

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

10. Usual occupation **Ax Grinder**

11. Industry or business _____

MOTHER FATHER { 12. Name **August Richter**

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

14. Maiden name **Rachel Strubinger**

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

16. (a) Informant **Mrs. Ida Richter**

(b) Address **2251 Wheaton Ave.**

17. (a) **Burial** (b) Date thereof **12/ /46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove**

18. (a) Signature of funeral director **Stroot-Carroll**

(b) Address **4600 Natural Bridge Ave.**

19. (a) **12-19-46** (b) **Ruth A. Allen**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis** **96**
Wellston
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. **2251 Wheaton Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **16**
year **1946** hour _____ minute _____ P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **fracture of right side of skull when struck by an automobile (pedestrian)** Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

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) **Accident.** **96**

(b) Date of occurrence **Dec. 16, 1946.**

(c) Where did injury occur? **St. Louis County, Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public road.

(Specify type of place) **Blunt im-**

While at work? _____ (e) Means of injury **Car**

23. Signature **Arnold J. Willmann** (M., D., or other) **3**

Address **Clayton, Mo.** Date signed **12/18/46**

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.....

....., Registered Apprentice* No.....
working under my personal supervision.

Signed

Ben E. Hoffman

Licensed Embalmer No. *7366*

P. O. Address *Albany, Ga*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.