MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8924

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 4003 Registered No. 2620

City St Louis (No. Jewish Hospital St. ..... Ward)

2. FULL NAME John A Wolfe

(a) Residence. No. ..... St., 12 Ward. Hildebrant Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 3 mos. 3 ds. How long in U.S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Mary Wolfe

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 8 - 1882

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
46	11	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cutter for 131
(b) General nature of industry, business, or establishment in which employed (or employer): Tailor 93
(c) Name of employer: 1070

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Hungary

PARENTS

10. NAME OF FATHER: Paul Wolfe
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Hungary
12. MAIDEN NAME OF MOTHER: Anna Mark
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Hungary

14. INFORMANT: Mary Wolfe
(Address): Hildebrant Mo

15. FILED ..... 27 1929 ..... 19..... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 26 1929

17. I HEREBY CERTIFY, That I attended deceased from 11-23 — 1928, to 2-26 — 1929 that I last saw him alive on 2-26 — 1929, and that death occurred, on the date stated above, at 6.25 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho pneumonia 5 da.
Nephritis chronica 1 year 3 mo ?
Myocarditis chronica 1 year 3 mo ?
Arteriosclerosis (duration) ? yrs. mos. ds.
Hypertension ?

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 129a

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) John A. Raich, M. D
19 (Address) Senior Jewish Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF ~~BURIAL, CREMATION,~~ OR REMOVAL: Madison Ill
DATE OF BURIAL: Feb 28 1929

20. UNDERTAKER: Francis J. Lahey
ADDRESS: Madison Ill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.