

MAR 28 1930

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

Do not use this space.
6240

1. PLACE OF DEATH
 County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6033B
 City Overland (No. _____) St. _____ Ward _____

2. FULL NAME John W. Walfrum
 (a) Residence No. 12321 Gaebler St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? 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 Catherine Wolfrum
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 12 1852
 AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 3 3
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1930
 17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1930, to death, 1930, that I last saw him alive on Feb 12, 1930, and that death occurred, on the date stated above, at 12 + A. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis of larynx - arteriosclerosis
108
97
2016 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) deglutition pneumonia
 (duration) _____ yrs. _____ mos. _____ ds.

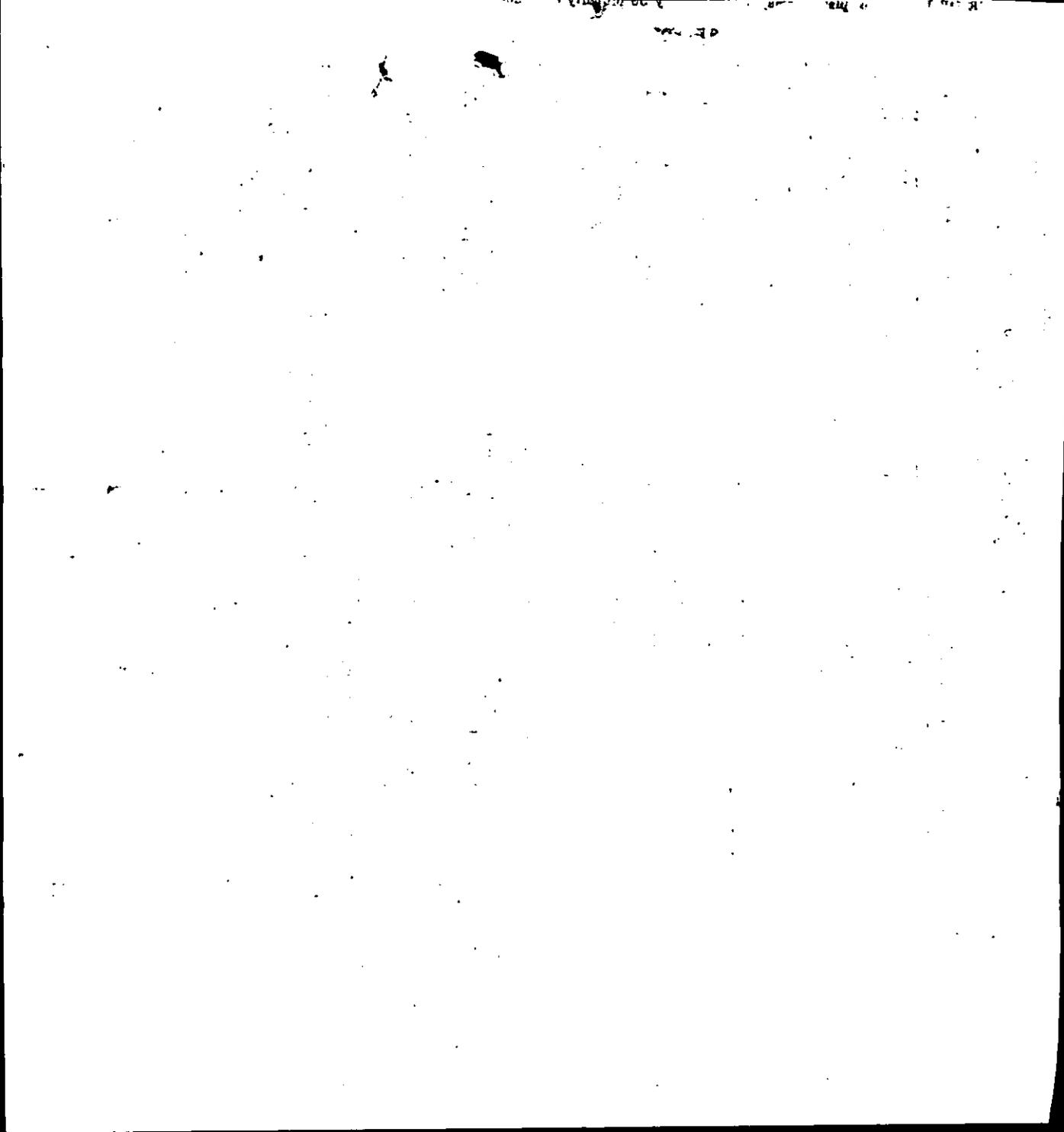
9. BIRTHPLACE (CITY OR TOWN) Wildon Springs Mo
 (STATE OR COUNTRY)
 10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) P. K. Whitener, M. D.
Feb 15, 1930 (Address) 2573 Woodson Road Overland Mo.
 *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.

14. INFORMANT Catherine Wolfrum
 (Address) 321 Gaebler Overland Mo
 15. FILED 2/16 1930 Allen Bray M.D. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Living St. Johns Cem. St. Charles Mo DATE OF BURIAL 2/18 1930
 20. UNDERTAKER Wainman Bros ADDRESS Overland Mo

31



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 789 File No.
Towship Primary Registration District No. 60 B 3 B Registered No. 571
City Overland (No.) St. Ward)

2. FULL NAME

John W. Wolfrum
(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/15 19 30

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

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

Paralysis of larynx
arteriosclerosis

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

Regulator pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Star
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed)....., M. D.
, 19 (Address)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
ADDRESS 19

15. FILED 2/16 1930 John W. Gray, M.D. REGISTRAR

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH in plain terms, to cause to comply de proprio officio with statement of cause of death

S-6240