

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.

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

Do not use this space.

**MAY 7 1937**

**791  
1003**

**14216**

**1. PLACE OF DEATH**

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City **ST. LOUIS**

(No. **4232 A W. BELLE PL.**)

File No.....

Registered No.....

St. .... Ward)

**2. FULL NAME CHARLIE WOLFF**

(a) Residence, No. 4232 A W. BELLE PL. St.

11 Ward.

(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**

**COL**

**5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)**

**MARRIED**

**5A. IF MARRIED, WIDOWED, OR DIVORCED**

HUSBAND OF (OR) WIFE OF

**DAISY**

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

**JULY 14, 1875**

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, .....hra. or .....min.

**61**

**8**

**19**

**NIL**

**OCCUPATION**

**8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.**

**9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.**

**10. Date deceased last worked at this occupation (month and year)**

**11. Total time (years) spent in this occupation**

**12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)**

**MISS.**

**FATHER MOTHER**

**13. NAME**

**SAMUEL WOLFF**

**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)**

**MISS**

**15. MAIDEN NAME**

**ELIZAVDEN**

**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)**

**MISS**

**17. INFORMANT (ADDRESS)**

**MRS. DAISY WOLFF  
4232 A W. BELLE PL.**

**18. BURIAL, CREMATION, OR REMOVAL**

PLACE **GREENWOOD**

DATE **4/7**

**1937**

**19. UNDERTAKER (ADDRESS)**

**R.M.E. GREEN  
3517 W. ACLEDE AVE**

**20. FILED**

**APR 7, 1937**

**J. F. Bredeck**

Registrar.

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)**

**4/3**

**1937**

**22. I HEREBY CERTIFY That I attended deceased from**

**Dec 15, 1936, to Mar 3, 1937**

I last saw him alive on **Mar 27, 1937**. Death is said

to have occurred on the date stated above, at **3:15 P.M.**

The principal cause of death and related causes of importance were as follows:

Date of onset

**Arteriosclerosis**

Other contributory causes of importance:

**Chronic Nephritis**

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

**23. If death was due to external causes (violence), fill in also the following:**

Accident, suicide, or homicide? Date of injury

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

**24. Was disease or injury in any way related to occupation of deceased?**

If so, specify

(Signed)

**Samuel Stafford**, M. D.

(Address)

**925 N. Jefferson**

