No. 2
1-10-39

FILED MAY 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 13672

Registrar's No. 3874

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: St Louis

(b) City or town: St Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community 1 11

2. USUAL RESIDENCE OF DEATH:

(a) State: Mo (b) County: 0

(c) City or town: St Louis 23 (If outside city or town limits, write "RURAL")

(d) Street No. 1527 So 3rd St (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Martin Woerfel

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: Single

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: Unknown (Month) (Day) (Year)

8. AGE: Years: abt 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace: Germany (City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business: 7

FATHER
12. Name: Unknown 9
13. Birthplace: " (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: "
15. Birthplace: " (City, town, or county) (State or foreign country)

16. (a) Informant: City Hospital
(b) Address: 3/1/40

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof: St Louis (Month) (Day) (Year)
(c) Place: burial or cremation: Bellefontaine Cem

18. (a) Signature of funeral director: W. Richter 3530 Rutger
(b) Address

19. (a) APR 30 1940 (Date received local registrar) (b) J. F. Bracheck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 21 year 1940 hour 5:50 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.

	Duration
Immediate cause of death: Lobar Pneumonia	
Due to:	
Due to: Coronary Thrombosis	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: NV

Of autopsy:

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)
(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? (Specify type of place)
While at work?
(e) Means of injury

23. Signature: Joseph M. Dorsey (M. D. or other)
Address: Doherty Coroner Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13672

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3874-

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:
.....
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Martin Woelfel -

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

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced .....

6. (b) Name of husband or wife ..... 6. (c) Age of husband, or wife, if alive ..... years.

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
65			..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) JAN 5 1941 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 21 - 40
year ..... hour ..... minute ..... 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 Lobar Pneumonia

Due to Aortic aneurysm

Due to Specific

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

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Major findings:
Of operations .....
Of autopsy .....

Duration

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) .....
(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?
..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

PERMANENT RECORD