

FILED MAR 25 1941 791

Registration District No.

1003

1269

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

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: St. Luke's Hospital  
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether \_\_\_\_\_)

In this community 17 yrs.  
years, months of day)

3. (a) PRINT FULL NAME Infant Wohlshlaeger

3. (b) If veteran, name war No

3. (c) Social Security No. None

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: Feb 5 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 1 1/2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Matthew Wohlshlaeger

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

14. Maiden name Dorothy Jane Dangler

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

16. (a) Informant Wm. M. Wohlshlaeger

(b) Address Ferguson, Mo.

17. (a) Burial (b) Date thereof 2/11/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jas. W. Cook

(b) Address 1125 St. Ferdinand Ave.

19. (a) \_\_\_\_\_ (b) J. M. Brudek  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 1098 Florissant Rd.  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 NR years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7  
year 1941 hour 4 minute 10 a.m.

21. I hereby certify that I attended the deceased from 2-5-41 19 to 2-7-41 19;  
that I last saw him alive on 2-7-41 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of Cecum

Due to congenital deformity of intestinal tract

Due to \_\_\_\_\_

Other conditions 157-77  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Rupture of Cecum

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury 1

23. Signature Wynell W. Davis (M. D. or other) \_\_\_\_\_  
Address 3722 Washington Date signed 2-7-41

FEB 7 1941

---

---

**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.

*No Embalming.*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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